Supreme Court, U.S.
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No. _____

In The

# Supreme Court of the United States

DREW FENTON and KLAUS WAGENER,

*Petitioners,*

v.

UNIHEALTH AMERICA, INC., et al.,

*Respondents.*

**On Petition For Writ Of Certiorari To The California Supreme Court**

## PETITION FOR WRIT OF CERTIORARI

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## QUESTION PRESENTED

Under 42 U.S.C. section 1395u, which limits the assignment of Federal funds earned by physicians who treat the poor, can those physicians assign the public funds due them to a corporation which engages them to work as independent contractors to staff a hospital emergency department?

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## PETITION FOR WRIT OF CERTIORARI

Petitioners Drew Fenton, M.D. and Klaus Wagener, M.D. respectfully pray that a writ of certiorari issue to review the decision of the Court of Appeal for the Second Appellate District of California herein.

## ORDERS BELOW

The December 28, 1998 decision of the California Court of Appeal is attached hereto as Appendix A. The Court of Appeal order of January 26, 1999 modifying that decision is attached hereto as Appendix B. The March 24, 1999 order of the Supreme Court denying Petitioner's petition for review is attached hereto as Appendix C.

## JURISDICTION

The California Supreme Court denied review herein on March 24, 1999. The jurisdiction of this Court is invoked under 28 U.S.C. § 1257(a), in that Petitioners' claim that the decision of Court of Appeal violates 42 U.S.C. § 1395u.

## STATUTES AND REGULATIONS INVOLVED

42 U.S.C. § 1395u(b)(6) (appended hereto as Appendix D).

42 C.F.R. 424.70, 424.71, and 424.80 (appended hereto as Appendix E).

## STATEMENT OF THE CASE

### A. Procedural History

On March 2, 1995, Dr. Drew Fenton and Klaus Wagener (hereinafter collectively Appellants) filed their Superior Court complaint for breach of contract, promissory fraud, accounting and breach of fiduciary trust against Defendants Heilpern, CEMS, CMC, Unihealth, Inc. and other individual defendants (hereinafter collectively Respondents). The complaint also included a cause of action in which Fenton alone alleged harassment and retaliation against Defendants Heilpern, CEMS, CMC and Unihealth (AA 1)

The answers to the complaint were filed by Defendants Heilpern and CEMS on May 4, 1995 (AA 83) and Defendants CMC and Unihealth on May 12, 1995 (AA 89).

On February 22, 1996, Plaintiffs filed dismissals as to individual defendants other than Heilpern (AA 94).

The causes of action of the complaint for promissory estoppel, breach of fiduciary duty and accounting were tried before Judge Richard P. Kalustian without a jury between May 13 and May 21, 1996. On June 4, 1996, the trial court filed its statement of decision finding for Respondents on all of those causes of action (AA 1133).

As to Fenton's cause of action for retaliation and harassment, the jury returned a special verdict 9-3 in

favor of Respondent on the basis that Fenton was an independent contractor and not an employee (AA 1485).

The judgment was appealed to the Court of Appeal for the Second Appellate District and in an opinion filed on December 28, 1998, affirmed by Division Seven of that Court. One of the issues raised on appeal was the violation of 42 U.S.C. § 1395u(b)(6) resulting from CEMS receipt of the Federal funds due Appellants under the Medicare and Medicaid programs (AOB 27-30). The Court of Appeal decided that question, concluding that the statute was not violated (see Appendix A). Appellants again raised the issue in their Petition for Review to the California Supreme Court. The Supreme Court denied review on March 24, 1999.

**B. Relevant Facts**

Appellant Fenton is a physician licensed in the State of California and board-certified in emergency medicine. His educational background consists of a bachelor of science degree in biology from Pennsylvania State University and an M.D. degree from Jefferson Medical College in Philadelphia. He served as an intern at Letterman Army Medical Center in San Francisco in internal medicine. Then he had two years of service overseas in Germany as an army medical officer. He served as a commanding officer of a medical detachment in Augsburg, Germany. When he returned to the United States after his service stint, he did a residency in emergency medicine at Los Angeles County USC Medical Center and became board-certified in emergency medicine passing the two examinations in 1989 and 1990

(RT 963:24-937:6). At the time of trial he was the medical director of the urgent care clinic of the H. Claude Hudson Comprehensive Health Care Center (RT 68:1-4).

He has been a member of professional societies, including the American Academy of Emergency Medicine (AAEM) and presently holds an elected seat on its Board of Directors. He was a founding member of the Academy. He has been on staff as an Assistant Professor of Clinical Emergency Medicine at Los Angeles County USC Medical Center (RT 939:6-12).

Dr. Fenton commenced work at CMC as an emergency department physician on or about July 1, 1989. At the time that he commenced work with CMC he was interviewed by Dr. Heilpern, president and owner of CEMS, the contract holder in charge of running the emergency department at CMC. CEMS is a one-man corporation that recruited the emergency physicians to work in the emergency department at CMC under his supervision. Fenton began working on a part-time basis at CMC for a specific hourly rate of approximately $65. In December of 1989, he commenced to work full-time under three written contracts prepared by Heilpern, which provided that Fenton would work 12-hour shifts (Exhibits 301, 400, 401).

Fenton continued to work as an emergency physician at CMC for the period from December, 1989 to on or about January 6, 1994, when he was denied any further shifts at CMC on orders from Dr. Heilpern (RT 117-18, 1059-63).

Appellant Wagener is a board-certified physician who has practiced the specialty of emergency medicine

since 1980. He received a bachelor of science degree from the University of Toronto in medical sciences. Subsequently he went to medical school at the University of Ottawa and graduated in 1977. He went from there to the University of Southern California Medical Center where he did both an internship and a residency. He completed his residency in emergency medicine in 1980.

From June, 1980 to February, 1981, he served as a physician at Alhada Hospital in Saudi, Arabia. He returned to Los Angeles and worked as an emergency physician at Henry Mayo Hospital in Valencia. For two years he worked at Tustin Community Hospital as an emergency physician. He worked at various emergency departments wherein a Dr. Fagan held exclusive contracts. He also served at Coastal Community Hospital, Robert F. Kennedy Hospital, Hospital of good Samaritan and at the Daniel Freeman Hospital. Commencing in April, 1990, he worked at CMC for CEMS and remained at CMC until April, 1993 (RT 350:1-10).

Wagener had no written contract with CEMS. Heilpern informed Wagener orally that he would work in the emergency department at an hourly rate as an independent contractor (RT 533:5-8).

The written contract presented to emergency physicians by CEMS and signed by Fenton provided that they would work in the emergency department at CMC on an hourly basis at a stipulated hourly rate as independent contractors. The contracts also provided that all of their billings would be owned by CEMS.

The emergency room served a largely indigent population of patients whose bills were paid from Medicare,

Medi-Cal and AB 75 (money provided by the state of California under Welfare and Institutions Code §§ 16975, *et seq.*) funds (RT 730-31). Billing for patient service was done by CEMS billing service, and Appellants were denied the opportunity to review the billing. Fees were paid directly to CEMS (RT 84:6-15, 88:20-26, 482:1-26, 490: 1-28).

Heilpern's fee as director of the emergency department at CMC was $10,000 a month. In addition, he received a subsidy of as much as $30,000 from the hospital for use in running the department. Heilpern also worked some shifts in the emergency department himself (RT 82:7-12). Heilpern also said that when there was a surplus left over at the end of the year in the corporate account, he would pay it to himself as profit (RT 742:1-743:1).

In the Fall of 1991, Dr. Heilpern offered a "productivity formula" payment plan as an alternative to payment on a straight hourly rate for emergency department physicians who opted for it. A physician who opted to be paid under the "productivity formula" received a reduced hourly base rate, and an additional sum which varied with the amount of money collected on the basis of that physician's billings (RT 89, 496).

According to Appellants, Heilpern represented that the pool available to pay the physicians under this formula was the entire amount generated by the group from patient billings, including Medi-Cal, Medicare, AB-75, plus the subsidies CMC contributed each month to CEMS, less CEMS' overhead for the month (RT 85:5-23, 87:4-8). (RT 496:8-25).

Heilpern testified that the pool of money from which the productivity supplements were paid was made up only of the amounts by which the hourly rates of those participating in the plan were reduced from their standard contract rate. According to Heilpern, that created a pool of approximately $35,000-$40,000 a month. By dividing the total collections for each physician reported to him by his billing company, Synergistic Systems, Inc., by the total collections for the month, he came up with a percentage for each individual physician and used that percentage as the basis for the productivity payments (RT 720:1-28-721:1-28).

Barry Gumerove, testifying as an expert witness on behalf of Respondents, supported Heilpern's analysis asserting that Heilpern's corporation would have no motive for existence if it operated as Appellants contended (RT 671:20-672:25, 675-76).

Heilpern said that he could not include the amount of AB-75 collected each month in determining each physician's percentage, because all the AB-75 was credited to his own account rather than being allocated to the individual physicians (RT 723:1-28-724:7-23).

Heilpern stated that the majority of the physicians in the Emergency Department opted to participate in the productivity formula (RT 734:4-27).

Arthur Sayles, C.P.A., testified as an expert witness on behalf of the plaintiffs. He reviewed the income and charges and receipts of CEMS to determine whether the allocations among the various doctors were correct. He was provided with the copies of billings, adjustments to billings and the payments received by CEMS for the

period from February 1, 1993, through January 31, 1994, including those relating to the AB-75 money provided by the state for indigent care. He also examined the monthly summaries made by Synergistic Systems, Inc., the billing company for CEMS. (RT 318:26-321:27).

Sayles noted that for the period under scrutiny the total charges were approximately four million dollars (RT 323:1-17). He noted that while records indicated that Heilpern's services accounted for $100,000 of the billings, it appeared that Heilpern collected approximately $600,000 (RT 324:17-325:13). He also stated that AB-75 billings for doctors' services accounted for about $430,000 or approximately 25 percent, of the total collections. The records showed that all of the AB-75 funds were credited to Heilpern's own account (RT 657, 692, 771; Ex. 197).

According to Sayles, the total funds credited to Heilpern were approximately $585,000, to Fenton, $93,500, and to Wagener, $59,000. Thus, Heilpern was credited with 32.5 percent of the gross receipts of the operation, while Fenton was credited with 5.2 percent and Wagener 3.3 percent. Sayles discovered, however, that while the percentages credited to Fenton and Wagener closely corresponded to the billings they generated, Heilpern had generated only 2.2 percent of those billings (RT 327:26-328:22).

Fenton testified that Heilpern stated frequently at emergency section meetings that the books were open to all the members of the group for their examination, but that he never received monthly summaries of the earnings that were attributable to the clinical services rendered by the physicians (RT 84:2-15). Heilpern agreed

that he received monthly statements from Synergistic Systems, Inc. but never gave them to the physicians who worked for him (RT 719, 739, 762-67). Appellants testified that their efforts to obtain financial records from Heilpern were consistently rebuffed (RT 482:1-26; 490:1-28; 571:12-22).

## REASONS FOR GRANTING THE WRIT

**The Petition Raises an Important Question as to the Operation of the Medicare System.**

This case raises a question of widespread importance as to the provisions by which Congress seeks to ensure that the physicians who actually provide care under the Medicare and Medicaid programs receive the Federal payments due for their services

### A. Legislative History

As shown in legislative history (House Report No. 95-393(II) (1977)), Congress acted in 1972 to "stop a practice under which some physicians and other person providing services under medicare and medicaid reassigned their medicare and medicaid receivables to other organizations or groups." Congress acted because it "had become apparent that such reassignments were a significant source of incorrect and inflated claims. . . . " *Ibid.*, at p. 26.

In the resulting legislation, Congress explicitly stated the policy that Medicare and Medicaid payments should be made to "the physician or other person who provided

the service," and implemented that policy by prohibiting the physicians providing services to Medicare and Medicaid patients from reassigning those payments. 42 U.S.C. § 1395u(b)(6).

The statute does make some exceptions to the reassignment prohibition, allowing physicians to reassign the billings under certain circumstances to their *employers*, § 1395u(b)(6)(A)(i), and to the *facilities* (such as hospitals, 42 C.F.R. 424.71) in which the care was provided. Section 1395u(b)(6)(A)(ii).

In 1977, Congress found that the prohibition was being circumvented by the use of powers of attorney, and moved to prohibit that means of moving payments from individual physicians to other companies and groups. House Report No. 95-393, pp. 26-27.

**B. Agency Action**

While the statute provides that *hospitals* can receive payments which the physician assigns them, 42 C.F.R. 424.80(b)(2), the relevant regulations make it clear that this does *not* include corporations or individuals which have exclusive contracts with hospitals. 42 C.F.R. 424.70 and 424.71. Further, the Health Care Financing Administration, the agency administering the funds, has held that such payments *should not* be made to an entity which contracts with the hospital to provide emergency department services, *unless* that entity is a *professional* corporation and the individual physicians are its *employees*.

In 1997, HCFA first discovered that it had been a practice since 1985 for individual physicians providing

services under the Medicare and Medicaid programs to reassign payments for those services to contract management groups like CEMS, even though they are not employees of the group. "HCFA Enforces Ban on Reassignment of Medicare Benefits," Emergency Medicine News (August 1997), p. 1. According to David Walczak, a health insurance specialist in the Division of Beneficiary and Insurance Issues at HCFA, there was particular concern about reassignment by independent contractor physicians, "because of the potential for fraud and abuse." HCFA therefore moved against that practice as well. *Ibid.*, p. 15.

Thus, the Manual of the HCFA Division of Benefit Services now makes it clear that, under § 1395u(b)(6)(A)(ii), the right of a hospital to receive payment *includes* cases where the hospital contracts with a *professional* corporation which *employs* the physicians which provide the services, but does *not* include contracts with a corporation which "subcontracts the responsibility for providing the emergency room services to physicians who are *independent contractors* (*emphasis added*)." In such a case, it is the physicians who *must* receive the funds, and cannot assign them.

The Manual makes the point through the use of examples. Example 1 (page 3-50) describes the situation in which a *professional* corporation enters into a contract to staff an emergency department with *employee* physicians. In that situation, the Manual states that the professional corporation *can* receive fees for the services of its employee physician, and that the hospital can do so if it enters into a separate contract with the physicians for that purpose.

Example 2 on page 3-50 departs from example 1 in that the corporation considered "subcontracts the responsibility for providing the emergency room services to physicians who are independent contractors (emphasis added)." That is precisely Respondents' situation. In such a case, the Manual states that

> [e]ven though *the corporation may not itself bill and receive the payments for the services*, the hospital may do so if it enters into direct contractual arrangements with the physicians for this purpose.

This Court has held that administrative interpretations of statutes have controlling weight unless arbitrary, capricious, or manifestly contrary to the statute, *Chevron, U.S.A. v. Natural Resources Defense Council*, 467 U.S. 837 at 843-44 (1984), and the regulations and HCFA interpretation should therefore be controlling here.

### C. The Facts of the Instant Case

Petitioners here are physicians who cared for Medicare patients under a contract with CEMS, a corporation which employed them to work in the hospital emergency department as independent contractors.

Under this arrangement, an example of the practice which, according to HCFA, has become common throughout the country since 1985, CEMS received all of the Medicare funds owed Petitioners for their services, and paid Petitioners an hourly salary and additional "incentive" bonuses which had no direct relationship to the amount of the Medicare payments.

In this action, Petitioners seek an accounting for the Medicare funds which were unlawfully assigned to CEMS and which CEMS continues to withhold from them.

The California Court of Appeal found in this case that CEMS lawfully received the payments due Petitioners under the exception for "facilities" in 42 U.S.C. § 1395u(b)(6)(A)(ii) (Opinion, pp. 19-20). In fact, however, neither the exception for "facilities" nor that for "employers" is applicable here, and the Court of Appeal thus represents an unwarranted watering-down of the effectiveness of a significant Congressional policy.

First, the exception for employers does not apply, because the jury found, as Respondents had maintained throughout the proceedings, that Appellants were not *employees* but independent contractors (AA 1485).

Second, as shown above, the exception for assignment to "facilities" is inapplicable as well, because it does not allow management companies or groups to receive assignments from the *independent contractor* physicians who staff emergency departments for them.

Thus, a corporation or other entity which provides staffing for an emergency department cannot receive the payments due the individual physicians unless it is willing to undertake the responsibilities involved in being their *employer*. Respondent here, like many such entities, is unwilling to undertake those responsibilities, preferring instead to insulate themselves by treating the physicians as "independent contractors."

The will of Congress, as interpreted by the agencies charged with applying it, is that entities which make that choice cannot then receive the Federal funds due the physicians for their services. Respondent, as shown in this case, has engaged in the very widespread practice which HCFA has now set out to extirpate as a serious challenge to Congressional intent.

Petitioners now ask this Court to take this case in order to ensure that Congressional intent is not frustrated by decisions of state courts such as that of the California Court of Appeal in this case, which erroneously validate contracts by which individual physicians are compelled to reassign the Federal Medicare and Medicaid funds they have earned to corporations and groups which treat them as independent contractors.

## CONCLUSION

For the reasons stated above, Petitioner respectfully requests that the writ be granted.

Dated: June 22, 1999 — Respectfully submitted,

ROBERT S. GERSTEIN
*Attorney for Petitioners,*
*Drew Fenton & Klaus Wagener*

**APPENDIX A**

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

THE COURT OF APPEAL OF
THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION SEVEN

| | |
|---|---|
| DREW FENTON, et al., Plaintiffs and Appellants, v. UNIHEALTH AMERICA, INC., et al., Defendants and Respondents. | B110722 (Super Ct. No. BC 123041) (Filed Dec. 28, 1998) |

APPEAL from a judgment of the Superior Court of Los Angeles County. Richard P. Kalustian, Judge. Affirmed.

Fizzolio & Fizzolio, Robert S. Gerstein and James M. Fizzolio for Plaintiffs and Appellants.

Musick, Peeler & Garrett, James B. Bertero; Rushfeldt, Shelley & Drake, Linda C. Miller and Christine T. Hoeffner for Defendant and Respondents.

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Appellants Drew Fenton, M.D. and Klaus Wagener, M.D. appeal from a judgment entered in favor of respondents California Medical Center, California Emergency Medicine Specialists, and Neil Heilpern, M.D. Drs. Fenton and Wagener were formerly emergency room doctors

at California Medical Center, and contend the trial court erred in finding a California Emergency Medicine Specialists and its owner Neil Heilpern did not owe appellants a fiduciary duty to account for their share of emergency room billings and also in finding no monies were wrongfully withheld from them. Appellant Fenton further contends the trial court erred by instructing the jury he could only recover on his claim for retaliatory termination in violation of the Fair Employment and Housing Act (FEHA) (Gov't Code § 12900, et seq.) if the jury found he was an employee of CEMS. Appellant also contends the court erred in finding Heilpern and CMC could not be liable on his retaliation claim on the grounds Heilpern was neither an agent of CMC nor could Heilpern be individually liable under the holding of *Janken v. GM Hughes Electronics* (1996) 46 Cal.App.4th 55.

## FACTUAL BACKGROUND AND PROCEDURAL HISTORY

Appellants Drew Fenton, M.D. (Fenton) and Klaus Wagener, M.D. (Wagener) both worked as emergency room doctors at the emergency room of respondent California Medical Center (CMC), an inner-city hospital primarily serving indigents located in downtown Los Angeles. The operation of the emergency room at CMC was contracted out to an entity known as California Emergency Medicine Services (CEMS) which in turn was owned and managed by respondent Neil Heilpern, M.D. (Heilpern).[1]

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[1] Heilpern also ran the emergency room at another hospital known as La Palma Intercommunity Hospital. Fenton also

A. Dr. Fenton's Employment With CEMS and the Partnership Negotiations.

Fenton worked at CEMS from July 1, 1989 to January 6, 1994, when he was denied any further shifts at CEMS pursuant to orders from Heilpern. While working at CEMS, Fenton worked 12-hour "shifts" which were scheduled in advance each month.

Sometime in 1991 or 1992, the emergency room physicians became interested in forming a partnership with Dr. Heilpern. In 1992, Heilpern began negotiations with the doctors with respect to forming a partnership with them. Ultimately, the negotiations fell through and in the Spring of 1993 Fenton began having problems with Heilpern. Heilpern testified the partnership with the physicians was never consummated because it would have required him to renegotiate CEMS' contract with CMC Because CMC could terminate CEMS' emergency room contract on 60 days' notice, Heilpern stated he determined it was best not to rock the boat. Therefore, sometime in March or April 1993, Heilpern informed the doctors he would not be going forward with the partnership. In protest, some of the emergency room doctors withheld their availability schedules[2] in response to what they perceived to be Heilpern's unfair refusal to enter into a partnership agreement. Fenton testified Heilpern

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worked intermittently there, but the issues raised on appeal center on Fenton's work at CMC for CEMS and Heilpern.

[2] These were schedules provided to the doctor staffing the emergency room on a monthly basis. The schedules gave the dates and times the doctors were available to work.

threatened to fire them if they did not turn in their availability schedules.

On March 13, 1993, Fenton gave the 60 days' notice required pursuant to his contract to Heilpern terminating his relationship with CEMS. Nevertheless, Heilpern continued to schedule Fenton during the 60-day period following Fenton's notice of termination. Heilpern testified at trial he read Fenton's termination letter to mean if the partnership did not go forward, Fenton wished to terminate his relationship with CEMS. In May 1993, Heilpern met with Fenton and told him Fenton should no longer expect to work at CEMS if no partnership was formed by May 1993. Fenton stated he wanted to continue working at CEMS even though the partnership had fallen through. Heilpern testified he kept Fenton on because he considered him a good doctor.

Fenton presented differing testimony. On May 13, 1993, Fenton and six other doctors met with Heilpern. One of the other doctors told Heilpern it was not fair to fire Fenton because Heilpern had no cause to fire him. Based on this, Heilpern gave Fenton two shifts a month. Fenton worked for CEMS intermittently during late 1993. Fenton requested six 12-hour shifts for May 1993 and Fenton in fact worked six 12-hour shifts. Fenton testified to an April 1993 conversation with Dr. Heilpern in which Heilpern told Fenton he was no longer wanted at the emergency room at CMC. Heilpern stated he was getting rid of Fenton because of a personal vendetta Heilpern had against him. Later when Fenton spoke to Heilpern by phone, Heilpern stated Fenton was not being "fired" because he was a poor doctor. Fenton spoke to James Yoshioka, the President of the Medical Center Division of

Unihealth,[3] regarding getting his shifts back and Yoshioka told Fenton he had been "shit" upon.

Heilpern had recruited other full-time physicians in response to Fenton's notice. In October 1993, Heilpern sent a memo to physicians stating he could not guarantee positions unless the physicians were willing to work full time (12 shifts a month). Thus, scheduling of physicians had become competitive, and the October 1993 memo was to clarify his position full-time physicians would be given preference in receiving shifts. The memo stated after December 1993 the emergency room would not be able to guarantee shifts to part-time doctors.

Fenton worked at the CMC emergency room until January 1994 when his brother died and he had to leave the state to attend the funeral. Fenton testified he notified CMC he had a family emergency, not specifically mentioning his brother's death. Fenton was later told he would be given no more shifts in the emergency room because he was unreliable given his hasty departure for his brother's funeral. At this time, Assistant Director Dr. Splawn was responsible for scheduling the emergency room physicians. Splawn was concerned with Fenton's reliability based on an October 1993 incident when Fenton called to say he was unavailable and did not take responsibility for finding a doctor to cover his shift. In January 1994 when Fenton called in to say he would not be able to cover his shift (without explaining there had been a death in the family), Dr. Splawn became seriously concerned about Fenton's availability. Because there were

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[3] Unihealth is the parent company of CMC.

not enough shifts in February to schedule all of the doctors who wanted shifts, Fenton was not placed on the February schedule.

On May 1, 1994, Heilpern left CMC and the operation of the emergency room was taken over by Dr. Splawn, who had been Heilpern's assistant.

B. The Productivity Formula.

Initially, the physicians in the emergency room, including Fenton, were compensated at a flat hourly rate. Sometime in the Fall of 1991, at the instigation of the emergency room physicians, Heilpern began using a "productivity formula" to pay the doctors. Heilpern and Fenton testified to differing versions of the productivity formula. Fenton testified a pool of funds was created from funds the emergency room received from insurance companies, AB-75,[4] Medicare, and MediCal, as well as Los Angeles County. Fenton claimed he did not sign a release assigning those funds to Heilpern. Fenton testified the productivity formula allocated to each emergency room doctor a percentage of these funds based upon the amount of work the doctor had done that month. Overhead was deducted from this pool prior to payment to the doctors. The doctors were paid at a reduced hourly rate plus their percentage. The purpose of the formula was to shift income to doctors who worked

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[4] Ab-75 uses tobacco tax funds to provide medical care to indigents. Dr. Heilpern was instrumental in getting this legislation passed.

harder, and Fenton believed the incentives would be better in the emergency room if the physicians received a portion of the revenues they generated, instead of being paid at the same hourly rate. Fenton testified his paychecks, which contained notations detailing his percentage for a particular month, reflected what he received, but did not directly reflect the size of the pool for that particular month.[5] Fenton testified Heilpern, who received a stipend of $10,000 per month from CMC, told Fenton he did not participate in the pool because his stipend was sufficient.

Heilpern testified the productivity formula was not based upon total funds received from various sources, but instead was based upon physician hours worked each month. Heilpern used each physician's billings for the month and divided them by the total revenues generated by the emergency room to yield a percentage figure representing that physician's "productivity." A pool of $35,000 to $40,000 was therefore generated each month by calculating the hourly rate times the hours worked by each physician. Thus, the pool would be distributed each month by giving each doctor a percentage of the pool which reflected the percentage their work contributed to the Medicare and insurance funds generated each month. The percentage payments from the pool was added to the base rate (a reduced hourly rate). Heilpern testified the productivity formula was designed to recognize variances in individual productivity.

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[5] An example paycheck contained the notation, "108 hours at $60/hour plus 6.9%."

Heilpern testified Fenton's version of the pool did not make economic or business sense because it was important to maintain a constant level of expenses from month to month as the emergency room's revenues fluctuated from month to month. Therefore, to keep the emergency room's expenses constant and the productivity pool budget neutral, the base rate pay of each physician was reduced and the different replaced by the percentage of productivity. Heilpern testified the productivity formula was not designed to be a "fee-for-service" type of arrangement (which is essentially Fenton's version) because such an arrangement would have created problems. Heilpern believed the physicians would be picking and choosing their patients based on their insurance benefits rather than medical need, or choosing difficult patients because they would generate more revenues. He also testified it would not have made sense to reduce the hourly rate if the pool actually consisted of all monies coming into the corporation.

Furthermore, Heilpern testified his billing company, Synergistics,[6] credited the AB-75 money to Heilpern in one lump sum and refused to credit each physician monies on account of work performed by that physician because it was too costly. Therefore, Heilpern calculated if a doctor was bringing in a certain percentage of billings for the month, he assumed it represented their share of the AB-75 monies. This was done instead of actually monitoring the indigent patients each doctor treated. Heilpern also testified it was not possible to pass along to

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[6] Synergistics Systems Incorporated handled the billing for CEMS.

the physicians all of the revenues generated by them because he would not have been able to pay the overhead expenses of the emergency room.

In addition, due to lag time in receiving monies from governmental sources such as AB-75, Medicare and Medi-Cal during some months, there were insufficient funds on had to pay the physicians and hence the pool envisioned by Fenton would not exist every month. Heilpern was often required to borrow funds from the Department of Health Services based on billings made in the past. These advances usually were around $100,000. If it was not possible to get an advance from DHS, Heilpern would borrow funds from a bank. Heilpern was personally liable on these loans, although they were made to the corporation. Synergistics charged 16½ percent of billings plus incidental expenses, so that billing charges worked out to about 18 percent per month.

Fenton's contract with CEMS provided "Independent Contractor shall not bill patients for services rendered by Independent Contractor. All billing shall be accomplished pursuant to the agreement between the Corporation and the Hospital. No payments made by hospital patients shall accrue to Independent Contractor relating to services provided pursuant to this Agreement. All such payments from hospital patients, if and when received by Independent Contractor, shall be immediately delivered and endorsed to the Hospital. Independent Contractor shall only be compensated pursuant to the provisions of paragraph 4 of this Agreement." Heilpern explained to each doctor hired by CEMS they would be assigning all of the rights they had to billing for patients to CEMS. CEMS would do the billing, generate revenues and pay the

physicians a fixed hourly rate from those revenues. At the end of the year Heilpern took out of the corporation the profit reached for the year, approximately $200,000 to $300,000. This was in addition to the $10,000 per month stipend received from the hospital. He also received a portion of the monthly billings.

Arthur Sayles, CPA, a specialist in forensic accounting, testified on behalf of Fenton. Sayles testified in reaching his opinion he reviewed materials received from Synergistics, including the emergency room's billings, adjustments to billings, and payments received by CEMS on account of AB-75 funds. He stated approximately $4 million was received by the emergency room during the relevant period. Heilpern's services accounted for about $100,000 of the billings, but Heilpern collected approximately $600,000. Heilpern generated 2.2 percent of the income, but received 32% and Fenton's billings accounted for 6.1 percent of total funds received. Sayles further testified the AB-75 funds accounted for about 25 percent of all receipts, and these funds were credited to Heilpern's account. The funds credited to Fenton and Wagener closely reflected the billings they generated. Sayles did not believe the books reflected all of the income, and testified he did not know what the productivity formula was, nor did he know whether any of the AB-75 money was refunded to the state.

Heilpern's expert, Barry Gumerove, CPA, testified he analyzed the productivity formula and concluded it accomplished a redistribution of income within the group of doctors. The ratio of each doctor's receipts determined the amount of pay he received. Gumerove testified CEMS

would have no profit motive for its existence if it operated as Fenton testified.

C. Testimony Concerning Fenton's Employment Status.

The emergency room physicians worked pursuant to a contract with CEMS. Fenton's contract with CEMS provided he was an "independent contractor." At the end of each year, Fenton received an IRS 1099 form from CEMS, rather than a W-2. No. taxes were withheld from his pay, and he represented to the IRS that he was self-employed.

Steven Culp, C.P.A., testified as an expert on behalf of Fenton. Culp stated he based his opinion on review of I.R.S. rulings, interviews with Drs. Wagener and Fenton, and documents, canceled checks, employment applications, and company forms. Culp did not review Fenton's tax returns, but a summary of them prepared by Jennifer Polhemus, an economist employed by Fenton. Culp also examined some I.R.S. reports prepared on Fenton's employment relationship with CEMS. Cult concluded Fenton was an employee of CEMS. Culp stated the most important factor in finding employee status was the amount of control CEMS exerted over Dr. Fenton. Medical protocols were given the doctors, such as preferences for certain drugs and the manner in which patient charts should be prepared. The emergency room doctors were supervised by a director of emergency services. Dr. Fenton did not provide his own equipment or staffing, or invest in the facilities. Dr. Fenton was paid a fixed hourly rate for his services, and did not take care of billing or accounting. In view of the 20 factors delineated by the

I.R.S. to distinguish employees for independent contractors, Culp opined Fenton was an employee of CMC, Unihealth, and CEMS.

On cross-examination, Culp stated he had not looked at Fenton's employment contracts with CEMS and was aware of the fact Fenton held himself out to the I.R.S. on tax returns as a "sole proprietorship." Jennifer Polhemus, an economist employed as an expert by Fenton to determine his lost earnings, reviewed Fenton's 1099s from 1989 onward, his income tax returns, pleadings and discovery taken in the case. Polhemus projected Fenton had lost $333,900 in income from 1994 to the date of trial.

D. Evidence Regarding Dr. Heilpern's Discrimination and Harassment.

*Kelly Incident.* On June 7, 1990, while on duty in the emergency room, Fenton heard a scream and looked over to witness Heilpern unbuttoning the buttons on Nurse Katie Kelly's calf-length dress. Kelly was the ward coordinator for the emergency room. Heilpern was laughing and Kelly was pushing him away. Two to four of the buttons on Ms. Kelly's dress were unbuttoned. Heilpern testified he was just kidding with Kelly and when he realized he offended her, he apologized. Kelly got up and went to the other side of the hallway and Fenton went over to console her. Kelly complained to her superiors, and a month or so later, Fenton was called in to discuss the incident with Mr. Patrelli, the Director of Human Resources for CMC. In addition, Heilpern asked Fenton to speak to his attorney and Fenton also spoke with Ms. Kelly's attorney. Prior to his meeting with Human

Resources, Fenton told Heilpern he had been asked to speak to them. Heilpern told Fenton prior to Fenton's meeting with Human Resources that Heilpern expected Fenton to be honest with Human Resources. Kelly commenced an action against CEMS which was settled out of court in January 1993. Heilpern testified he did not hold any animosity towards Fenton for speaking with Human Resources, and in fact was thankful for Fenton's testimony because he believed Kelly was exaggerating his conduct.

*Noll Incident.* On several occasions in 1992 and 1993, Fenton observed Heilpern approach Jan Noll, a secretary at the emergency room, pull on her skirt and grab at her blouse. On one occasions, Heilpern grabbed Noll's buttocks and embarrassed her. When Fenton asked, Noll told Fenton she tolerated these incidents because she needed her job.

*Fenton Incident.* At the Official CEMS Christmas party in December 1992, held at Fenton's home, Heilpern walked up behind Fenton in Fenton's kitchen as Fenton was bending over a cooler to pull out a beverage. Heilpern began making thrusting movements with his pelvis against Fenton's buttocks. Fenton became humiliated and immediately left the kitchen.

*Akinwole Incident.* Dr. Akinwole, an emergency doctor at CMC, complained to Fenton after the Christmas party. she said Heilpern had made inappropriate advances to her and grabbed her buttocks at the party.

E. Fenton's DFEH Complaints.

On September 17, 1993, Fenton filed claims against CEMS, CMC and Unihealth with the Department of Fair Employment and Housing (DFEH). Fenton alleged harassment based on sex and orientation, but did not allege retaliation. Fenton contends CEMS received a copy of his complaint on December 21, 1993, as he presented at trial a copy date-stamped with CEMS' date stamp "Received '93 Dec 21 Personnel.' " Heilpern, however, claimed he had not seen the complaint.

The FEHA issued right to sue letters on December 15, 1993. On March 1, 1994, Fenton filed another claim with the DFEH against CEMS, CMC, and Unihealth. This time he alleged he had been fired, laid off, harassed, denied a promotion and denied the opportunity to function properly as an emergency room physician. Fenton further alleged he was discriminated against based on his sex, his orientation, and retaliated against based on his participation in the Kelly harassment investigation. Right to sue letters on the second round of DFEH complaints were issued on March 3, 1994. Heilpern testified he had no knowledge of Fenton's DFEH complaints at the time he stopped putting Fenton on the emergency room schedule.

F. The Bifurcated Trial.

On March 2, 1995, appellants filed their complaint against Unihealth, America, Inc., CMC, CEMS, Heilpern, and other individuals. Appellants alleged eight causes of action: Claims by Fenton and Wagener for promissory estoppel (first and second causes of action), accounting (third cause of action), breach of fiduciary duty (fourth

case of action), denial of due process (fifth cause of action), Fenton's claim of sexual discrimination and harassment in violation of FEHA (sixth cause of action), and Fenton and Wagener's claims of fraud (seventh and eight causes of action).

The trial court granted respondents' summary judgment motion on the fifth, seventh and eighth causes of action, and held a bench trial on the first through fourth causes of action. The court found for respondents and filed its statement of decision. In rejecting appellant's claims for breach of fiduciary duty and accounting, the trial court found Heilpern did not intend to create a pool of money from emergency room billings and in any event, all monies were properly distributed to appellants.

On the remaining sixth cause of action, the matter was tried to a jury. The trial court granted Heilpern and CEMS' motion *in limine* to exclude evidence of harassment other than the Kelly incident on the grounds of relevance. The trial court granted motions for non-suit as a Unihealth, CMC, and Heilpern. CMC was dismissed from the lawsuit on the basis Heilpern was not an employee of CMC and therefore CMC could not be held liable for his conduct. Heilpern was dismissed on the basis an individual is not liable for personnel decisions pursuant to *Janken v. GM Hughes Electronics* (1996) 46 Cal.App.4th 55. CEMS was the only remaining defendant. The jury was instructed it could only find for Fenton if they found he was an employee of CEMS. Finding Fenton was not an employee of CEMS, the jury did not reach the question of whether retaliation had occurred and returned a verdict for CEMS.

## DISCUSSION

Appellants seek to resurrect on appeal the third, fourth and sixth causes of action for accounting, breach of fiduciary duty, and Fenton's claim of retaliation in violation of FEHA against CMC, CEMS, and Heilpern. On appeal, Fenton argues the trial court erred with respect to the sixth cause of action by (1) instructing the jury he could not recover on his retaliation claim unless he was an employee, (2) limiting Fenton's evidence on the retaliation claim to evidence of the Kelly harassment incident, (3) holding Heilpern, as a matter of law, could not be personally liable for harassment against Fenton, (4) holding CMC was not liable for Heilpern's harassment and retaliation. Both Wagener and Fenton argue the trial judge erred in finding for respondents on their cause of action for accounting and breach of fiduciary duty because (1) Heilpern and CEMS were fiduciaries because they collected public funds from indigent patients, and (2) the undisputed evidence establishes a balance due to appellants which can only be ascertained by an accounting.

### I. FENTON'S RETALIATION CLAIM IS WITHOUT SUPPORT IN FACT OR LAW.

Conceding his independent contractor status, on appeal Fenton argues the trial court erroneously instructed the jury he could not recover from CEMS unless he was an employee. Fenton also argues the trial court erred in holding Heilpern could not be individually liable to Fenton for retaliating against Fenton for Fenton's protest of Heilpern's harassment, and in holding CMC

could not be liable for Heilpern's actions. Finally, Fenton contends the trial court erroneously limited evidence of harassment to the Kelly incident.

We disagree. Not only did Fenton have an independent contractor arrangement with CEMS, precluding coverage by the FEHA, the facts demonstrate Fenton cannot state a claim for retaliation under the FEHA because he cannot show Heilpern's actions were causally connected to either the Kelly incident or Fenton's DFEH complaints, or that Heilpern's explanation for his actions were a pretext. Because Fenton cannot state a claim for retaliation, we do not address the issue of entity and individual liability for retaliation (Heilpern, CEMS, or CMC). Finally, we conclude the trial court properly excluded on grounds of relevance the evidence of harassment other than the Kelly incident.

### A. An Independent Contractor Cannot Recover Under FEHA's Provisions Prohibiting Retaliation.

Fenton contends the trial court improperly instructed the jury he had to be an employee of CEMS in order to recover against CEMS for retaliation under Government Code section 12940, subdivision (f). Fenton argues section 12940, subdivision (f) is not limited to employees because it prohibits retaliation by an employer not only against employees but "against any person opposing any forbidden practice." (*Fisher v. San Pedro Peninsula Hospital* (1989) 214 Cal.App.3d 590, 615.) Fenton therefore contends an independent contractor can bring a retaliation claim. (*See Sada v. Robert F. Kennedy Medical Center* (1997) 56

Cal.App.4th 138, 143-144 [FEHA applied to plaintiff applying for work with defendant while an independent contractor].) We disagree. Although the statutory language lends some support to Fenton's arguments, DFEH decisions and case law interpreting FEHA are clear FEHA does not apply to independent contractors.

Fenton interprets the language of section 12940, subdivision (f),[7] to cover independent contractors because it prohibits retaliation against any "person," not just any "employee." However, FEHA has not been given such an expansive interpretation. Instead, the FEHC and courts interpreting the FEHA have consistently taken the position FEHA does not cover independent contractors. (*See, e.g., Fisher v. San Pedro Peninsula Hospital (1989)* 214 Cal.App.3d 590, 608, fn.6; *DFEH v. Children's Hospital and Health Center* (1987) FEHC Dec. No. 87-24; *Lumia v. Roper Pump Co.* (N.D. Cal. 1989) 724 F.Supp. 694, 697-698 [following FEHC position on independent contractors].) Furthermore, FEHC regulations state that "[e]mployee does not include an independent contractor as defined in Labor Code Section 3353." (Cal. Code of Regs., tit. 2, § 7286.5, subds, (b) and (b)(1).) In turn, Labor Code section 3353 defines an independent contractor as "any person who renders service for a specific recompense for

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[7] Section 12940 provides: "It shall be an unlawful employment practice, unless based upon a bona fide occupational qualification, . . . ¶ (f) For any employer, labor organization, employment agency, or person to discharge, expel, or otherwise discriminate against any person because the person has opposed any practices forbidden under this part or because the person has filed a complaint, testified, or assisted in any proceeding under this part."

a specific result, under the control of his principal as to the result of his work only and not as to the means by which such result is accomplished." Because we give great weight to an administrative agency's interpretation of its own regulation, we conclude FEHC does not apply to independent contractors. (*See Robinson v. Fair Employment & Housing Commission* (1992) 2 Cal.4th 226, 234, 235, fn.6.)

Furthermore, *Sada* does not hold independent contractors are for all purposes covered by FEHA. Instead, *Sada* held FEHA applied to protect applicants for employment because to find otherwise would undermine the principles of FEHA by permitting retaliation against job applicants. (*Sada, supra,* at p. 160.) In *Sada,* it was therefore coincidental and not necessary to the court's decision that the complainant was an independent contractor, and the court stated, "Sada's termination claim is not premised on her status as an independent contractor" and expressly limited its holding to employees and applicants for employment. (*Sada, supra,* at pp. 159, 160, fn. 29.) Therefore, *Sada* does not provide any authority for extending FEHA coverage to independent contractors.

### B. Fenton Cannot Establish Any Casual Link Between the Kelly Incident and His DFEH Complaints and His Termination, or That Heilpern's Explanation for His Termination Was Pretextual.

Under FEHA, an employer may not "retaliate" against an employee because the employee has opposed practices forbidden by FEHA (unlawful discrimination or harassment) or has filed a complaint with the DFEH or

assisted with DFEH proceeding. (Gov. Code, § 12940, subd. (f).) A claim for retaliation is asserted as follows: (1) the plaintiff must establish a prima facie case of retaliation, (2) the defendant must articulate a legitimate non-retaliatory explanation for its actions, and (3) the plaintiff must show the defendant's proffered reasons are pretextual. (*Flait v. North American Watch Corp.* (1992) 3 Cal.App.4th 467, 476.) To make out a prima facie case of retaliation, the plaintiff must show (1) he engaged in a protected activity, (2) he was thereafter subjected to adverse employment action by his employer, and (3) there was a causal link between the protected activity and the adverse employment action. (*Fisher v. San Pedro Peninsula Hospital* (1989) 214 Cal.App.3d 590, 614.) With respect to causation, the employee must show the adverse action followed the protected activity within a relatively short time. (*Id.*) We hold Fenton failed to establish either the necessary element of causation or that Heilpern and CEMS' legitimate, non-retaliatory explanation for his termination were pretextual.

The evidence presented to the trial court (Fenton and Heilpern's testimony) failed to establish any causal link between his protests concerning Heilpern's conduct and his DFEH complaints on the one hand and his termination on the other. The evidence was conflicting whether Heilpern in fact knew of Fenton's DFEH complaint when Fenton was removed from shifts at the hospital. Heilpern claimed he knew nothing of it, while Fenton contends Heilpern received a copy of it in December. The jury was entitled to believe Heilpern's testimony he had no knowledge of it and thus it did not provide a basis for Fenton's termination. The Kelly incident, having taken place over

three years previous to Fenton's termination, was too remote in time to have been a cause of Fenton's termination. (*See Flait v. North American Watch Corp.* (1992) 3 Cal.App.4th 467, 478 [inference of retaliation warranted where employee who had worked for company for four years with satisfactory reviews was laid off within a few months of making a harassment report].)

Second, Heilpern had been recruiting other physicians to cover Fenton's position because Fenton had given his 60-day notice. In the Fall of 1993 Heilpern determined to give priority to "full-time" workers, believing they had more of a commitment to the emergency room. At this time, Fenton was working intermittently and part-time in the emergency room. Fenton had failed on two occasions to obtain physicians to cover his emergency room duties when Fenton was unable to perform his shifts. Both Heilpern and Dr. Splawn were concerned with Fenton's reliability, particularly since Fenton failed to provide what Dr. Splawn and Heilpern considered an explanation for his sudden absence in January 1994, and did not obtain anyone to "cover" for him. This lack of reliability was a legitimate business reason, not a pretext, for terminating Fenton.

### C. The Trial Court's Limitation of Evidence to the Kelly Harassment Incident Was Not an Abuse of Discretion.

Finally, Fenton argues the trial court erred in excluding evidence of other incidents of Heilpern's harassment. The trial court limited the evidence to the Kelly incident because it believed this was the only incident which

could form the basis of a harassment claim, as it was the only incident Fenton reported to anyone else. Fenton contends, however, his DFEH claims were filed in December 1993, and listed complaints against CMC, CEMS *and* Heilpern. These DFEH claims covered all harassment incidents that Fenton witnessed, as well as his own harassment. Therefore, Fenton contends because these claims were received by respondents in late December 1993, and the claims can form the basis of a retaliation claim, the trial court erred in excluding the evidence.

We disagree. Even assuming respondents CEMS and Heilpern received the DFEH complaints in December 1993 (a fact which respondents dispute), evidence of the individual incidents of harassment are not relevant to whether Fenton was retaliated against for either (a) reporting the Kelly incident or (b) filing the DFEH complaints. Thus, although the trial court may have considered the evidence irrelevant on another basis, we do not find its ruling in error. Because the issue before the jury was retaliation and not harassment, the cumulative effect of the numerous incidents of harassment would tend to prejudice the jury against Heilpern as he was the alleged harasser in all of the incidents. The evidence would have been properly excluded on that basis.

## II. THE TRIAL COURT DID NOT ERR IN FINDING HEILPERN OWED NO FIDUCIARY DUTY TO FENTON AND WAGENER AND THEREFORE THEY WERE NOT ENTITLED TO AN ACCOUNTING

Fenton and Wagener argue Heilpern was their fiduciary because he collected funds, including the AB-75 tobacco tax funds, on their behalf. (*Michelson v. Hamada*

(1994) 29 Cal.App.4th 1566.) They also argue because Medicare does not permit the assignment of funds received on account of care for indigents, any purported contractual assignment of the AB-75 funds to Heilpern was ineffectual. (42 U.S.C. § 1395u(b)(6).) They further argue the undisputed evidence establishes there is a balance of emergency room funds due appellants. Respondents CEMS and Heilpern contend substantial evidence supports the trial court's findings no fiduciary duty existed because of the contractual agreement between the parties and also argue neither Medicare nor AB-75 prohibit the assignments of funds.

### A. Substantial Evidence Supports the Trial Court's Findings Heilpern was Not Acting as a Fiduciary for Wagener and Fenton.

Whether a fiduciary relationship exists in any given situation is a question of fact. Thus, we will uphold the trial court's finding none existed between Fenton and Wagener on the one hand and Heilpern on the other if such finding is supported by substantial evidence. (*Michelson v. Hamada* (1994) 29 Cal.App.4th 1566, 1576.) A fiduciary relationship is created where one party reposes trust and confidence in the other to use utmost faith in handling their affairs. If Heilpern had been acting as an agent and collecting funds on behalf of Wagener and Fenton, this would have created a fiduciary relationship. (*Recorded Picture Company, Ltd. v. Nelson Entertainment, Inc.* (1997) 53 Cal.App.4th 350, 370.) However, mere contractual relations, negotiated at arm's length, do not create a fiduciary relationship. (*Id.*)

The record demonstrates Fenton and Wagener assigned by contract their interest in the AB-75 and other medical benefit funds to Heilpern and/or CEMS. By making an absolute assignment of these funds in exchange for the hourly rate of pay they received, Fenton and Wagener were relieved of the risk of collecting those funds, which came in on an intermittent basis. Because of the contract, Heilpern was not collecting these funds on their behalf and hence could not be acting as their fiduciary. *Hamada*, upon which appellants rely, is distinguishable on this basis. In *Hamada*, one doctor specifically agreed to collect professional fees on behalf of the other doctor in exchange for administering the office accounts. (*Hamada, supra*, at p. 1576.) Thus, in *Hamada*, one doctor agreed to be the fiduciary for the other. No such agreement to collect funds on behalf of Drs. Fenton and Wagener exists in this case; instead, appellants absolutely assigned their right in the funds to Dr. Heilpern.

In order to escape this assignment of funds, Fenton and Wagener contend any such assignment is invalid under the laws applicable to Medicare and AB-75. They contend the funds can only be paid to the doctor who performs the services. (See, e.g., 42 U.S.C. § 1395u(b)(6); Welf. & Inst. Code §§ 16953.1, 16953.2.) Appellants argue the exceptions to assignment do not apply here, and the funds cannot be reassigned because (a) Fenton was not an employee (therefore the "employer" exception to the prohibition on assignment does not apply), and (b) the funds can only be paid to a professional corporation contracting to provide emergency room services when the services are provided by employee physicians.

We do not agree. The federal Medicare statute provides in relevant part: "No payment under this part for a service provided to any individual shall . . . be made to anyone other than such individual or . . . other person who provided the service, except that payment may be made to the employer or such physician or other person . . . or (where the service was provided in a hospital, critical access hospital, clinic, or other facility) to the facility in which service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service . . . " (42 U.S.C. § 1395u(b)(6)(A)(ii); 42 C.F.R. 424.80(b)(2).) Appellants nevertheless contend the Health Care Financing Administration has consistently held the fees cannot be paid to an entity which contracts to provide emergency services unless the entity is a professional corporation of which the physicians are employees. Appellants cite to the Manual of HCFA Division of Benefit Services, of which they have requested us to take judicial notice.[8] However, we do not see why an agency administering the Medicare funds would adopt a view that is contrary to the plain language of the federal statutes providing such funds may be paid to a care facility. We therefore reject appellants' position federal law prohibits assignment of the funds.

We also disagree California law prohibits any assignment of AB-75 or other state or county funds. Section 16953.1 of the Welfare & Institutions Code governs

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[8] We have denied appellants' request to take judicial notice of the HCFA Manual.

receipt of funds from the Emergency Medical Services Fund and provides in relevant part: "Notwithstanding any other provisions of this chapter, an emergency physician and surgeon, or an emergency physician group, with a gross billings arrangement with a hospital shall be entitled to receive reimbursement from the physician services account in the county's emergency medical services fund for services provided in that hospital, if all of the following conditions are met: [¶ ](a) The services are provided in a basic or comprehensive general acute care hospital emergency department. [¶ ](b) The physician and surgeon is not an employee of the hospital. [¶ ](c) All provisions of Section 16955 are satisfied [limits on reimbursements for losses due to patient non-payment]. [¶ ](d) Reimbursement from the physician services account in the county's emergency medical services fund is sought by the hospital or the hospital's designee, as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group. [¶ ](c) For purposes of this action, "gross billings arrangement" means an arrangement whereby a hospital serves as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group, a percentage of the emergency physician and surgeon's or group's billings for all patients." We do not see how this language precludes an assignment of funds or the arrangement Drs. Wagener and Fenton had with Dr. Heilpern. Rather, it provides that emergency room physicians are entitled to receive Emergency Medical Services Funds even though the hospital may bill for the services on their behalf.

**B. Fenton and Wagener Failed to Establish the Productivity Formula Was Improperly Administered.**

Fenton and Wagener contend the undisputed evidence establishes Heilpern misappropriated funds, which therefore entitles them to an accounting. Appellants contend because the fees billed and received for their services in the emergency room far exceed the hourly rate they received, there is a balance due. We disagree. Appellant's position is based upon their interpretation of the operation of the productivity formula. They argue it represented a portion of funds actually received each month on account of each physician's work. However, this argument ignores the fact the trial court was entitled to believe Heilpern's version of the productivity formula, which did not involve any division of AB-75 funds or other funds coming into the hospital. Instead, under Heilpern's version, the productivity formula was based upon the doctor's percentage of the billings each month. Each doctor received a percentage of the pool (created from the reduced hourly rates) based upon their productivity. This explanation of the implementation of the productivity formula is entirely plausible, given Heilpern also testified the amount of money coming into the emergency room each month fluctuated greatly. Fenton's expert's testimony to the effect Heilpern received a greater percentage of the total funds coming in does not change this result, because the productivity formula was not a simple division of funds but a division of a specific pool of funds created from the doctor's own reduced hourly wages, not the actual funds received by the emergency room. It represented a redistribution among the

doctors of their own wages, not a redistribution to them from Heilpern of the emergency room's profits. Thus, analyzing the question from the standpoint of gross receipts does not establish any misappropriation by Heilpern, who as the owner of the business was entitled to keep the profits.

## DISPOSITION

The judgment of the superior court is affirmed. Respondents to recover their costs on appeal.

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS.

JOHNSON, J,

We concur:

LILLIE, P.J.

NEAL, J.

## APPENDIX B

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION SEVEN

| | |
|---|---|
| DREW FENTON, et al.,<br>Plaintiffs and Appellants,<br>v.<br>UNIHEALTH AMERICA, INC., et al.,<br>Defendants and Respondents. | B110722<br>(Filed Jan. 26, 1999)<br>(Super. Ct. No. BC123041)<br>ORDER DENYING PETITION FOR REHEARING AND MODIFYING OPINION<br>(NO CHANGE IN JUDGMENT) |

THE COURT:*

IT IS ORDERED the opinion filed herein on December 28, 1998 be modified in the following particulars:

On page two, at line three and at line five, delete the words "Neil Heilpern" and replace them with the words "Alan Heilpern."

On page two, at the last line of the second paragraph, delete the words "Neil Heilpern" and replace them with the words "Alan Heilpern."

On page 20, at footnote 8, delete the text of the footnote and replace it with the following: "Initially, this court denied appellants' request to take judicial notice of

the HCFA Manual, but on reconsideration, granted their request."

The petition for rehearing is denied. This modification does not effect a change in the judgment.

/s/ Lillie
*LILLIE, P.J.

/s/ J. Johnson
JOHNSON, J.

/s/ Neal
NEAL, J.

## APPENDIX C

Second Appellate District, Division Seven,
No. B110722 S076492

IN THE SUPREME COURT OF CALIFORNIA

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DREW FENTON Et Al., Appellants

v.

UNIHEALTH AMERICA INCORPORATED Et Al.,
Respondents

(Filed Mar. 24, 1999)

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Appellants' petition for review DENIED.

GEORGE
Chief Justice

# APPENDIX D

42 U.S.C. § 1395u

* * *

(6) No payment under this part for a service provided to any individual shall (except as provided in section 1395gg of this title) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that (A) payment may be made (i) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (ii) (where the service was provided in a hospital critical access hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service, (B) payment may be made to an entity (i) which provides coverage of the services under a health benefits plan, but only to the extent that payment is not made under this part, (ii) which has paid the person who provided the service an amount (including the amount payable under this part) which that person has accepted as payment in full for the service, and (iii) to which the individual has agreed in writing that payment may be made under this part, (C) in the case of services described in clause (i) of section 1395x(s)(2)(K) of this title, payment shall be made to either (i) the employer of the physician assistant involved, or (ii) with respect to a physician assistant who was the owner of a rural health clinic (as

described in section 1395x(aa)(2) of this title) for a continuous period beginning prior to August 5, 1997 and ending on the date that the Secretary determines such rural health clinic no longer meets the requirements of section 1395x(aa)(2) of this title, for such services provided before January 1, 2003, payment may be made directly to the physician assistant; and (D) payment may be made to a physician for physicians' services (and services furnished incident to such services) furnished by a second physician to patients of the first physician if (i) the first physician is unavailable to provide the services; (ii) the services are furnished pursuant to an arrangement between the two physicians that (I) is informal and reciprocal, or (II) involves per diem or other fee-for-time compensation for such services; (iii) the services are not provided by the second physician over a continuous period of more than 60 days; and (iv) the claim form submitted to the carrier for such services includes the second physician's unique identifier (provided under the system established under subsection (r) of this section) and indicates that the claim meets the requirements of this subparagraph for payment to the first physician. No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a

payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this subchapter is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment. For purposes of subparagraph (C) of the first sentence of this paragraph, an employment relationship may include any independent contractor arrangement, and employer status shall be determined in accordance with the law of the State in which the services described in such clause are performed.

* * *

# APPENDIX E

## CODE OF FEDERAL REGULATIONS
## TITLE 42 – PUBLIC HEALTH
## CHAPTER IV – HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES
## SUBCHAPTER B – MEDICARE PROGRAM
## PART 424 – CONDITIONS FOR MEDICARE PAYMENT
## SUBPART F – LIMITATIONS ON ASSIGNMENT AND REASSIGNMENT OF CLAIMS

Current through May 14, 1999; 64 FR 26632

§ 424.80 Prohibition of reassignment of claims by suppliers.

(a) Basic prohibition. Except as specified in paragraph (b) of this section, Medicare does not pay amounts that are due a supplier under an assignment to any other person under reassignment, power of attorney, or any other direct arrangement.

(b) Exceptions to the basic rule. –

(1) Payment to employer. Medicare may pay the supplier's employer if the supplier is required, as a condition of employment, to turn over to the employer the fees for his or her services.

(2) Payment to a facility. Medicare may pay the facility in which the services were furnished if there is a contractual arrangement between the facility and the supplier under which the facility bills for the supplier's services.

(3) Payment to health care delivery system. Medicare may pay a health care delivery system if there is a

contractual arrangement between the system and the supplier under which the system bills for the supplier's services.

(4) Payment to a government agency or entity. Subject to the requirements of the Assignment of Claims Act (31 U.S.C. 3727), Medicare may pay a government agency or entity under a reassignment by the supplier.

(5) Payment under a reassignment established by court order. Medicare may pay under a reassignment established by, or in accordance with, the order of a court competent jurisdiction, if the reassignment meets the conditions set forth in § 424.90.

(6) Payment to an agent. Medicare may pay an agent who furnishes billing and collection services to the supplier, or to the employer, facility, or system specified in paragraphs (b) (1), (2) and (3) of this section, if the conditions of § 424.73(b)(3) for payment to a provider's agent are met by the agent of the supplier or of the employer, facility, or system. Payment to an agent will always be made in the name of the supplier or the employer, facility, or system.

(c) Rules applicable to an employer, facility, or system. An employer, facility, or system that may receive payment under paragraph (b)(1), (b)(2), or (b)(3) of this section will itself be considered the supplier of those services for purposes of the rules of Subparts C, D, and E of this part.

[54 FR 4027, Jan. 27, 1989]

**CODE OF FEDERAL REGULATIONS**
**TITLE 42 – PUBLIC HEALTH**
**CHAPTER IV – HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**SUBCHAPTER B – MEDICARE PROGRAM**
**PART 424 – CONDITIONS FOR MEDICARE PAYMENT**
**SUBPART F – LIMITATIONS ON ASSIGNMENT AND REASSIGNMENT OF CLAIMS**
Current through May 14, 1999; 64 FR 26632

§ 424.71 Definitions.

As used in this subpart, unless the context indicates otherwise –

"Court of competent jurisdiction" means a court that has jurisdiction over the subject matter and the parties before it.

"Facility" means a hospital or other institution that furnishes health care services to inpatients.

"Health care delivery system" or "system" means a public or private organization for delivering health services. The term includes, but is not limited to, clinics and health care prepayment plans.

"Power of attorney" means any written documents by which a principal authorizes an agent to –

(1) Receive, in the agent's name, any payments due the principal;

(2) Negotiate checks payable to the principal; or

(3) Receive, in any other manner, direct payment of amounts due the principal.

# CODE OF FEDERAL REGULATIONS
# TITLE 42 – PUBLIC HEALTH
# CHAPTER IV – HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES
# SUBCHAPTER B – MEDICARE PROGRAM
# PART 424 – CONDITIONS FOR MEDICARE PAYMENT
# SUBPART F – LIMITATIONS ON ASSIGNMENT AND REASSIGNMENT OF CLAIMS

Current through May 14, 1999; 64 FR 26632

§ 424.70 Basis and scope.

(a) Statutory basis. This subpart implements sections 1815(c) and 1842(b)(6) of the Act, which establish limitations on who may receive payments due a provider or supplier of services or a beneficiary.

(b) Scope. This subpart –

(1) Prohibits the assignment, reassignment, or other transfer of the right to Medicare payments except under specified conditions;

(2) Sets forth the sanctions that HCFA may impose on a provider or supplier that violates this prohibition, or on a supplier that violates the conditions to which it agreed in accepting assignment from the individual; and

(3) Specifies the conditions for payment under court-ordered assignments or reassignments.

Supreme Court, U.S.
FILED
JUL 23 1999
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No. 98-2052

In The

# Supreme Court of the United States

DREW FENTON, M.D. and KLAUS WAGENER,

*Petitioners,*

vs.

UNIHEALTH AMERICA, INC., et al.,

*Respondents.*

**On Petition For A Writ Of Certiorari To The Supreme Court Of California**

## RESPONDENTS' ALAN HEILPERN, M.D. AND CALIFORNIA EMERGENCY MEDICINE SPECIALISTS MEDICAL GROUP, INC. BRIEF IN OPPOSITION

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3218

## ADDITIONAL QUESTIONS PRESENTED

1. Does the United States Supreme Court have jurisdiction, and should review be granted, of a factually intensive medicare issue analyzing how 42 U.S.C. § 1395u (entitled "Use of carriers for administration of benefits") applies to petitioners as independent contractor doctors when petitioners did not raise this issue in the trial court and instead asserted at trial that they were employees?

2. Is review of a federal issue proper – here, application of 42 U.S.C. § 1395u – where there are nonfederal grounds under the substantial evidence standard of review resulting in the state court's decision finding no breach of fiduciary duty and that petitioners were not entitled to an accounting?

## PARTIES TO PROCEEDING

The petition identifies only respondent "UNI-HEALTH AMERICA, INC." in the caption. It does not identify, as required by Rule 14 subdivision 1(b), all respondents in the caption or in a list within the petition.

Other parties to the state court lawsuit included defendants California Emergency Medicine Specialists Medical Group, Inc. ("CEMS") and Alan Heilpern, M.D., represented by Rushfeldt, Shelley & Drake LLP, and California Medical Center, Los Angeles ("Medical Center"), who is represented by separate counsel.

## RULE 29.1 LISTING

CEMS has no parent corporation and there is no publicly held corporation owning 10% or more of the corporation's stock.

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## OPINIONS AND ORDERS BELOW

The documents listed below are reprinted in the Respondent's Appendix ("RA") to this opposition.

Petitioners' May 30, 1996 "REQUEST FOR STATEMENT OF DECISION AS TO FIRST, SECOND, THIRD AND FOURTH CAUSES OF ACTION" is at RA 1-5.

The trial court's June 4, 1996 "STATEMENT OF DECISION" on the first through fourth causes of action tried by the court is at RA 6-8.

## JURISDICTION PROBLEMS

Petitioners assert this court has jurisdiction over the factually intensive question of whether 42 U.S.C. § 1395u applies to foreclose petitioners – two doctors – from assigning medicare proceeds to a medical corporation. But petitioners did not comply with the Rule 14, subdivision 1(g)(i)[1] requirement that in showing this court has jurisdiction, the petition must specify

> the stage in the proceedings, both in the court of first instance and in the appellate courts, when the federal questions sought to be reviewed were raised; the method or manner of raising them and the way in which they were passed on by those courts.

Petitioners cannot comply with Rule 14 because they did not ask the trial court to address the issue they now

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[1] All rule citations are to the United States Supreme Court Rules, effective May 3, 1999.

raise (RA 1-5), so the trial court did not pass on it (RA 6-8). Petitioners instead raised it for the first time on appeal. The California Court of Appeal rejected petitioners' argument, and had sufficient nonfederal grounds to support the opinion under the substantial evidence standard of review. This court does not review issues not properly raised below, nor does it review issues on which there is a sufficient alternative nonfederal basis for the state court opinion.

## STATEMENT OF CASE

### 1. Overview

In this factually intensive case, petitioners were emergency room doctors who sued defendants and respondents Medical Center, CEMS – the corporation responsible for staffing the Medical Center's emergency room, and Alan Heilpern, M.D. – CEMS's owner. Petitioners asserted they were entitled to a share in all profits earned by CEMS, and sued CEMS and Heilpern for (1) breach of contract/promissory estoppel, (2) an accounting, and (3) breach of fiduciary duty. In addition, petitioner Drew Fenton individually filed a cause of action under California's Fair Employment and Housing Act ("FEHA"; Cal. Govt. Code § 12940).

Petitioners' claims seeking CEMS's profits were decided in a bench trial. This was followed by a jury trial on Fenton's FEHA claim. All claims were unsuccessful. A judgment against petitioners was entered based on the decision of the trial judge from the bench trial and the jury verdict on Fenton's remaining FEHA cause of action.

The resulting final judgment was affirmed in full on appeal.

Petitioners ask this court to review the unpublished California appellate opinion affirming the judgment in favor of CEMS, Alan Heilpern, M.D., and Medical Center. But the issue petitioners now raise (1) was never asserted at the trial level, (2) is factually the opposite of what petitioners did assert, which was that they were employees, not independent contractors, and (3) was rejected by the court of appeal after it applied nonfederal law to affirm the judgment.

**2. The Trial.**

At trial, petitioners claimed CEMS and Heilpern breached a fiduciary duty and that petitioners were entitled to an accounting that would give them all profits of CEMS. Their argument was that Heilpern, who owned CEMS, who had to obtain personal loans to pay the physicians when funds were not timely received, and who incurred all the financial risk under the staffing contract with the Medical Center, was required to disperse all profits to the doctors, so that he would have no profit motive and at best would only break even for all of his efforts in staffing the Emergency Room and paying that staff. AA 6-11.

But the evidence at trial was that petitioners agreed to be paid and in fact were paid a guaranteed hourly rate plus a percentage of a pool reflecting their percentage contributions of public and insurance funds collected for the month, and in return, the doctors assigned to CEMS

all such funds received for treating emergency room patients. AA 24.

During the bench trial, petitioners insisted and in fact introduced extensive expert testimony that they were *employees* of CEMS. They also called as a trial witness Barbara Rawinowitz, a representative from American Insurance Administrators (i.e., the "carrier" in this case who would be regulated by section 1395u). She provided no testimony that any medicare funds were improperly paid in violation of section 1395u.

Petitioners never asked the judge presiding over the bench trial to make a finding as to whether 42 U.S.C. § 1395u, which expressly regulates medicare "carriers", entitled *petitioners* to more money from *CEMS*, or to decide whether petitioners were employees or independent contractors which might have impacted an analysis of whether section 1395u applied.[2]

After a full bench trial, the trial judge rejected petitioners' claims for more money.

### 3. The Appeal

The court of appeal affirmed the entire judgment, finding there was substantial evidence to support the findings from the bench trial, and that there was no error as to the jury trial portion of the case. AA 1-28.

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[2] In the subsequent jury trial, the jury was asked to decide whether Fenton was an employee for the purpose of entitling him to seek recovery under the FEHA.

In reviewing the bench trial portion of the judgment, the court of appeal rejected petitioners' new claim, raised for the first time on appeal, that 42 U.S.C. § 1395u somehow mandated a different result and a finding that petitioners' assignments of funds were void.

Petitioners filed a petition for rehearing, and CEMS and Heilpern filed an answer, both identifying factual errors in the opinion. The court issued an order that corrected certain parts of the opinion but did not change the holding. AB 1-2.

Petitioners filed a petition for review to the California Supreme Court for review of the FEHA issue and the 42 U.S.C. § 1395u issue. That petition was denied. AC-1.

**4. Summary Of Why This Petition Should Be Denied.**

The petition for writ of certiorari should be denied because

(1) There are multiple and serious failures of jurisdiction:

(a) petitioners never raised the issue at trial and never obtained a ruling from the trial court on the factually intensive issue they now ask this court to decide,

(b) the factual and legal arguments petitioners made at trial (they asserted they were employees) are the opposite of what they now assert (they assert they are entitled to a recovery because they were independent contractors), and

(c) the court of appeal opinion is based on an independent and adequate nonfederal ground; the court of appeal must presume that the trial court made all factual findings supported by substantial evidence necessary to support the judgment and there was substantial evidence under California law to support the trial judge's finding of no breach of fiduciary duty and no right to an accounting,

(2) The issue does not involve conflicting opinions or important issues of law,

(3) The statute in question expressly regulates medicare carriers. It was not enacted to give doctors a right to rescind fully performed agreements with Medical Groups. Petitioners should not be rewarded for changing their position after trial so they can dishonor an agreement that CEMS has fully performed.

**5. Misrepresentations Concerning The Facts And Procedural Posture.**

The petition fails to disclose that during both the bench trial portion of the case and jury trial portion, petitioners aggressively asserted that they were *employees* of CEMS, not independent contractors. They introduced expert testimony at both phases of trial that they were CEMS employees. (3 RT 393-401; 7 RT 1074-1083.) Because petitioners asserted throughout trial that they were employees, the "independent contractor" issue they now raise contradicts their trial position.

The petition fails to disclose that petitioners did not argue at trial, nor did they request that the trial court

decide, that 42 U.S.C. § 1395u foreclosed independent contractors from assigning medicare funds. RA 1-5.

The petition fails to disclose that the contracts petitioners entered into with CEMS to provide emergency room services stated that petitioners assigned to CEMS all of the money they generated from public funds or other sources that paid for treatment of patients, and in return, petitioners were guaranteed and paid an hourly fee by CEMS. (1 RT 70, 74; 2 RT 354-355; 4 RT 715-719; exhs. 304-306.)

The petition fails to disclose that at trial petitioners called as a witness Barbara Rawinowitz, a representative from American Insurance Administrators (i.e., the "carrier" in this case). She provided no testimony that any medicare funds were improperly paid.

## REASONS FOR DENYING THE PETITION

### I. THERE IS NO JURISDICTION TO GRANT CERTIORARI BECAUSE PETITIONERS DID NOT TIMELY RAISE THIS FACTUALLY INTENSIVE ISSUE IN THE TRIAL COURT WHERE PETITIONERS TOOK A FACTUALLY AND LEGALLY OPPOSITE POSITION.

Generally, petitioners must follow state procedure in timely raising a federal question. When required by state practice, the federal issue must be raised initially in the trial court. In California, petitioners are required to raise an issue at the trial level to preserve the issue for appellate review, otherwise it is deemed waived. *Marriage of*

*Arceneaux*, 51 Cal.3d 1130, 1133-1134 (1990); *Marriage of Hoffmeister*, 191 Cal.App.3d 351, 359 (1987).

In a nonjury trial, the trial court is required, upon timely party request, to render a "statement of decision" explaining the factual and legal basis for its decision as to each principal controverted issue for which any party requests such a statement. Cal. Code Civ. Proc. § 632.

Petitioners requested a statement of decision from the trial court but their request did *not* ask the judge to address the question of whether 42 U.S.C. § 1395u was violated by any party or prohibited petitioners from assigning their right to medicare funds, or whether the medicare carrier violated 42 U.S.C. § 1395u by paying medicare funds to CEMS.[3] RA 1-5. Nor did it request the trial judge to decide whether petitioners were employees

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[3] The portion of 42 U.S.C. § 1395u that petitioners claim was violated is subdivision (b)(6)(A) and (B), which state in pertinent part:

> (A) payment may be made to the (i) employer of such physician or other person . . . or (ii) (where the service was provided in a hospital . . . ) to the facility in which service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service, (B) payment may be made to an entity (i) which provides coverage of the services under a health benefits plan, but only to the extent that payment is not made under this part, (ii) which has paid the person who provided the service an amount . . . which that person has accepted as payment in full for the service, and (iii) to which the individual has agreed in writing that payment may be made under this part,. . . .

or independent contractors. RA 1-5. The trial court issued a statement of decision that did not mention 42 U.S.C. § 1395u or medicare, since it was never asked to do so.[4] RA 6-8.

On appeal, the statement of decision provides a record of the trial court's reasoning on particular disputed issues, which the appellate court may review when deciding whether the decision is supported by the evidence and law. *Marriage of Ditto*, 206 Cal.App.3d 643 (1988). Where a party fails to timely bring an alleged deficiency, omission, or ambiguity in a requested statement of decision to the trial court's attention, the defects in the statement are waived unless clarification was timely requested before entry of judgment. Cal. Code Civ. Proc. § 634; *Marriage of Arceneaux*, 51 Cal.3d 1130, 1133-1134 (1990). The appellate court then must assume the existence of any findings favorable to respondent in support of the judgment. *Marriage of Arceneaux*, 51 Cal.3d 1130, 1133-1134 (1990); *Marriage of Hoffmeister*, 191 Cal.App.3d 351, 359 (1987).

Applying this law to the appeal of the bench trial determination of various issues, the Court of Appeal in affirming the judgment (1) applied the substantial evidence standard of review, (2) found under the facts in the record that there was substantial evidence to support the trial judge's findings, (3) could reject – as waived and

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[4] Petitioners also made no claim or argument as to 42 U.S.C. § 1395u in their complaint, in either of their two trial briefs, or in their arguments at trial. It's no wonder the trial court never addressed the issue.

inconsistent with the substantial evidence test – petitioners' new claim that their assignments of funds were void under 42 U.S.C. § 1395u, and (4) could reject petitioners' 1395u argument as contrary to their theory of trial – petitioners offered no testimony from the carrier of any impropriety in payment of medicare funds, and instead insisted and presented evidence at both the bench trial and in the jury trial portion of the case that they were employees, not independent contractors.

The issue petitioners now raise – whether section 42 U.S.C. § 1395u prevents *independent contractors* from assigning funds – was simply never raised or decided at trial, since it was inconsistent with petitioners' theory of trial which was that they were *employees*. In fact, petitioners put on extensive expert testimony at trial claiming they were employees. AA 11-12; 3 RT 393-401; 7 RT 1074-1083. The trial court was not asked, nor did its statement of decision make any findings as to 42 U.S.C. § 1395u or petitioners' status as employees or independent contractors. RA 6-8.[5] Petitioners also conceded they assigned all medicare funds to CEMS. In view of these facts and the implied findings required of a statement of decision, the court of appeal had only one proper choice under the applicable standard of review, which was to affirm the trial court's judgment on the statement of

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[5] Only *after* the bench trial and statement of decision issued, did the jury trial proceed and result in a special verdict against Fenton alone on his FEHA cause of action finding that he was not an employee. Even after the jury concluded that Fenton was not an employee, he did not go back to the court and ask it to determine the effect of section 1395u on the statement of decision if he was not an employee.

decision and to reject petitioners' late raised claim that 42 U.S.C. § 1395u somehow mandated a different result.

Similarly, the court of appeal rejected petitioners' claim that the interpretation of 42 U.S.C. § 1395u by the HCFA Medicare Carriers Manual allowed them to avoid their assignment of medicare funds because they were not CEMS employees. Petitioners had requested the court of appeal to take judicial notice of the Medicare Carriers Manual, section 3060.2, while at the same time conceding that it did not even exist during trial or when the contract between petitioners and CEMS was in effect. The court of appeal made no detailed finding or analysis concerning application of its provisions to the facts of the case, or to the trial evidence. The court of appeal simply stated that it did not know why the HCFA would take a position contrary to the express language of the medicare statute.

The court of appeal's conclusion that there was substantial evidence in support of the statement of decision fully addresses the issue on a nonfederal basis, and is correct based on the rule of inferred findings of the trial judge. No further analysis was needed as to 42 U.S.C. § 1395u.

Nor do the court of appeal's cursory, advisory comments rejecting petitioners' 1395u argument provide a sufficient analysis to make review of this part of the opinion useful. The issue is both factually intensive and legally complex and should not be addressed here in a hypothetical situation after petitioners (1) failed to give the trial court any opportunity to address the issue, and

(2) took an opposite factual and legal approach throughout trial, asserting they were employees and not independent contractors.

## II. THE PETITION SHOULD BE DENIED BECAUSE AN ADEQUATE AND INDEPENDENT NONFEDERAL GROUND SUPPORTS AND MANDATES THE STATE COURT OPINION.

Where an adequate and independent nonfederal ground exists to support a decision, the supreme court has no jurisdiction to review the case. *Fox Film Corp. v. Muller*, 296 U.S. 207, 210, 211 (1935).

> Our only power over state judgments is to correct them to the extent they incorrectly adjudge federal rights. And our power is to correct wrong judgments, not to revise opinions. We are not permitted to render an advisory opinion, and if the same judgment would be rendered by the state court after we corrected its view of federal laws, our review would amount to nothing more than an advisory opinion. . . . [and even if] it is not clear whether the judgment rests on a federal ground or an adequate state one, this Court will not review. *Herb v. Pitcairn*, 324 U.S. 117, 125-26 (1945), disapproved in part on other grounds by *Michigan v. Long*, 463 U.S. 1047 (1983).

An adequate and independent nonfederal ground supports the court of appeal's decision denying petitioners' claims for breach of fiduciary duty and an accounting.

State law determined whether there was a breach of fiduciary duty, and whether an accounting was required.

And the substantial evidence standard of review controlled the court's review of the trial court findings on these issues. The opinion correctly concluded "Substantial Evidence Supports the Trial Court's Findings Heilpern was Not Acting as a Fiduciary for Wagener and Fenton." AA 22-24. The court also found based on substantial evidence that petitioners failed to establish they were denied any funds under the contract, and there was no misappropriation by Heilpern, who was entitled to keep the profits from the business. AA 6-11, 27-28. Thus, no accounting was justified.

Petitioners' unsuccessful theory at trial was that they were entitled to an accounting because they did receive all the profits and the productivity formula was not properly administered. They relied on state law in asserting their right to recovery. But there was voluminous, substantial evidence from trial that supported the trial court's decision rejecting plaintiffs' accounting and breach of fiduciary duty claims. AA 6-11.

The trial evidence established that pursuant to the agreement between petitioners and CEMS, CEMS paid petitioners a timely and guaranteed hourly rate of pay plus a percentage of a pool of insurance and public funds for their work in the emergency department. CEMS then bore the entire burden, expense, and risk of the collection efforts required to obtain the insurance and public funds petitioners assigned to it, which included significant delays and overhead costs in procuring the funds. Heilpern also incurred the expense and risk of obtaining personal loans to pay the doctors when public or insurance funds were not promptly received.

Petitioners' complaint and trial strategy did *not* include a claim for rescission of their assignment of funds on the ground that it was void, invalid, or contrary to 42 U.S.C. § 1395u. They knew any rescission claim would be fruitless where, as here, they had already ratified the agreement by accepting all the benefits and full performance under the contract for five years without questioning the assignment provision. *Neet v. Holmes,* 25 Cal.2d 447, 458 (1944) [a party knowing facts warranting rescission ratifies the contract by continuing to accept its benefits and may not thereafter rescind the agreement]. It was too late to void or rescind the assignment after it was fully performed. That is why at trial petitioners' approach was to simply seek additional funds by presenting a factual claim that funds should have been distributed differently under the productivity formula.

Although not expressly discussed in the court of appeal opinion, there was another basis for rejecting petitioners' 1395u argument; petitioners waived any claim based on 42 U.S.C. § 1395u because they did not ask the trial court to make any findings or ruling based on that theory. The waiver is understandable since their 1395u theory contradicts their trial theory where they insisted they were employees.

Independent and adequate state grounds support the judgment.

## III. PETITIONERS DO NOT MEET THE RULE 10 STANDARDS FOR REVIEW ON A WRIT OF CERTIORARI.

The state court of last resort here made no decision conflicting with another court, and no federal question was raised by petitioners at the trial level. Thus, the Rule 10(b) requirements for review are not met.

Rule 10(c) provides for review when

> a state court . . . has decided an important question of federal law that has not been, but should be, settled by this Court, or has decided an important federal question in a way that conflicts with relevant decisions of this Court.

But the state trial court in this case did not decide *any* question of federal law, nor does the court of appeal opinion conflict with any other decision or decide with any precision the question raised here – whether independent contractor physicians can assign medicare benefits to a medical corporation in exchange for a fixed fee for their services. The court of appeal opinion's mention of section 1395u is very brief. There is nothing for this court to review and no law to be settled.

## IV. THE FACT SPECIFIC MEDICARE ARGUMENT IS MERITLESS; SECTION 1395U WAS ENACTED TO REGULATE MEDICARE "CARRIERS", BUT NO CARRIERS ARE PARTIES TO THIS ACTION SO IT CANNOT BE THE BASIS FOR CHALLENGING THE JUDGMENT.

Petitioners' issue – albeit convoluted – proceeds as follows. They cite a statute regulating *medicare carriers*,

they ask this court to interpret the statute to regulate *doctors*, and they then attempt to force *CEMS* to pay them money on the theory that they, as doctors, violated the statute by assigning funds to CEMS. Logic is absent.

Title 42 U.S.C. § 1395u is entitled "Use of carriers for administration of benefits". This is part of the medicare administration statute, which expressly allows "carriers" to be used to administer medicare benefits. 42 U.S.C. § 1395u(a). "Carrier" is defined by 42 U.S.C. § 1395u(f), which provides that a "carrier" is a

> non-governmental organization which is lawfully engaged in providing . . . the cost of, health services under group insurance policies or contracts . . . in consideration of premiums or other periodic charges payable to the carrier. . . .

This is not a case about or against medicare carriers or any other insurer authorized to administer medicare payments. There is no claim that any defendant was a medicare carrier or that any carrier violated 1395u. In fact, petitioners even called a representative from American Insurance Administrators (i.e., the "carrier" in this case), Barbara Rawinowitz, as a witness at trial. She provided no testimony that any medicare funds were improperly paid. There was no evidence that the medicare carrier in this case violated section 1395u.

The statutory regulations controlling medicare "carriers" cannot be used, as petitioners attempt, to get money from CEMS by asserting *petitioners* violated 1395u, and therefore *CEMS* owes them money. The statutory provision petitioners rely on directly regulates medicare

carriers – not doctors, not medical corporations, not hospitals.[6] There is no provision in the statute allowing doctors to use the statute as a sword, to avoid and rescind their assignment contracts and obtain medicare money – not from the medicare "carrier", but from non-carrier individuals or corporations to whom the doctors assigned those funds.

Petitioners rely on an HCFA "Medicare Carriers Manual" in trying to support their petition. The provisions they cite from the carriers' manual were never presented or argued to the trial court. The manual did not even exist either at the time of trial or from 1989 to 1994, the contract years in question.

Moreover, given the trial evidence and the rule of implied findings supporting the statement of decision, nothing in the medicare statute forbids petitioners from (1) assigning their rights to such funds to CEMS, (2) allowing the carrier to pay CEMS the funds, and (3) allowing CEMS to collect the funds.

Petitioners' issue is meritless.

---

[6] Petitioners also assert that the regulations covering section 1395u provide that medical corporations cannot receive medicare payments. Cert. Pet. 10. But the regulations they cite contain no such provisions.

## CONCLUSION

For all of the reasons stated above, the petition for a writ of certiorari should be denied.

Dated: July 23, 1999

Respectfully submitted,

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**SUPERIOR COURT OF THE STATE OF CALIFORNIA**

**FOR THE COUNTY OF LOS ANGELES**

| | |
|---|---|
| DREW FENTON, M.D.<br>KLAUS WAGENER, M.D.<br><br>Plaintiffs,<br><br>v.<br><br>UNIHEALTH AMERICA, INC. ET. AL.<br><br>Defendants. | CASE NO: BC 123041<br><br>REQUEST FOR STATEMENT OF DECISION AS TO FIRST, SECOND, THIRD AND FOURTH CAUSES OF ACTION<br><br>(Filed May 30, 1996) |

Plaintiffs, DREW FENTON, M.D. and KLAUS WAGENER, M.D., in the above-entitled action, hereby requests that the court issue a statement of decision explaining the factual and legal bases for its decision regarding the following controverted issues:

FIRST CAUSE OF ACTION

1. Whether or not Plaintiff WAGENER should be entitled to a judgment of damages for Breach of Promissory Estoppel on the part of Defendants, ALAN HEILPERN and CALIFORNIA EMERGENCY MEDICINE SPECIALISTS, INC.;

2. Whether or not Plaintiff WAGENER should be entitled to a judgment of damages for Breach of Implied-In-Fact Employment Contract between Plaintiff and Defendants HEILPERN and CALIFORNIA EMERGENCY MEDICINE SPECIALISTS, INC.;

SECOND CAUSE OF ACTION

3. Whether or not Plaintiff FENTON should be entitled to damages for Breach of Promissory Estoppel on the part of Defendants, ALAN HEILPERN and CALIFORNIA EMERGENCY MEDICINE SPECIALISTS, INC.;

4. Whether or not Plaintiff FENTON should be entitled to a judgment of damages for Breach of Implied-In-Fact Employment Contract between Plaintiff and Defendants HEILPERN and CALIFORNIA EMERGENCY MEDICINE SPECIALISTS, INC.;

THIRD CAUSE OF ACTION

5. Whether or not Plaintiffs WAGENER and FENTON are entitled to an accounting from Defendants HEILPERN and CALIFORNIA EMERGENCY MEDICINE SPECIALISTS, INC. with full disclosure of all financial matters including billings and earnings pertaining to said

Plaintiffs employment as emergency physicians at CALIFORNIA MEDICAL CENTER.

FOURTH CAUSE OF ACTION

6. Whether or not Defendants HEILPERN and CALIFORNIA EMERGENCY MEDICINE SPECIALISTS, INC. agreed orally that they would act as each of the Plaintiffs agents for the purpose of collecting billings of each Plaintiff for his services in the emergency department at CALIFORNIA MEDICAL CENTER and that they would render true and correct accountings to each of the Plaintiffs for and on account of the amounts received and amounts disbursed.

7. Whether or not said Defendants HEILPERN and CALIFORNIA EMERGENCY MEDICINE SPECIALISTS, INC. have a duty to render a formal accounting to said Plaintiffs as fiduciaries.

DATED: May 29, 1996

FIZZOLIO & McLEOD
AND ROBERT GERSTEIN

BY: /s/ James M. Fizzolio
James M. Fizzolio
Attorney for Plaintiffs,
DREW FENTON, M.D.
and
KLAUS WAGENER, M.D.

**PROOF OF SERVICE**

**STATE OF CALIFORNIA, COUNTY OF LOS ANGELES**

I am employed in the County of Los Angeles, State of California. I am over the age of 18 and not a party to the within action; my business address is: 15260 Ventura Boulevard, Suite 1230, Sherman Oaks, California 91403.

On May 29, 1996 I served the foregoing document described REQUEST FOR STATEMENT OF DECISION AS TO THE FIRST, SECOND, THIRD AND FOURTH CAUSES OF ACTION the interested parties in this action by placing a true copy thereof enclosed in a sealed envelope addressed as follows:

Linda Miller, Esq.
RUSHFELDT, SHELLEY & DRAKE
12925 Riverside Drive, Fourth Floor
Sherman Oaks, CA 91423

James Bertero, Esq.
MUSICK, PEELER & GARRETT
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San Diego, CA 92101-5028

[X] BY MAIL

[ ] I deposited such envelope in the mail at Sherman Oaks, California. The envelope was mailed with postage thereon fully prepaid.

[X] As follows: I am "readily familiar" with the firm's practice of collection and processing correspondence for mailing. Under that practice it would be deposited with U.S. postal service on that same day with postage thereon fully prepaid at Sherman Oaks, California in the ordinary course of business. I am aware that on motion of the party served, service is presumed

invalid if postal cancellation date or postage meter date is more than one day after date of deposit for mailing in affidavit. Executed on May 29, 1996 at Sherman Oaks, California.

[ ] BY PERSONAL SERVICE, I delivered such envelope by hand to the addressee. Executed on ___ at Sherman Oaks, California.

[X] State I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

[ ] Federal I declare that I am employed in the office of a member of the bar of this court at whose direction the service was made.

/s/ Lisa Gaur
Lisa Gaur

**SUPERIOR COURT OF THE STATE OF CALIFORNIA**
**FOR THE COUNTY OF LOS ANGELES**

| | |
|---|---|
| DREW FENTON, M.D.; KLAUS WAGENER, M.D.,<br>Plaintiffs,<br>vs.<br>UNIHEALTH AMERICA, INC., a corporation; ALAN HEILPERN, M.D., an individual,<br>Defendants. | Case No. BC 123041<br>STATEMENT OF DECISION<br>(Filed Jun. 4, 1996) |

The first through fourth causes of action were tried in Department 17 of the above-entitled court, May 13 - 21, 1996. Plaintiffs were represented by James M. Fizzolio of Fizzolio and McLeod and defendant were represented by Linda Miller and Gordon Kojima of Rushfeldt, Shelley and Drake. Oral and documentary evidence was received. On May 20, 1996, defendants' motion for nonsuit was granted as to the first and second causes of action pursuant to Code of Civil Procedures section 631.8 and denied as to the third and fourth causes of action. The court's statement of decision as to the first through fourth causes of action follows

1. *Promissory Estoppel – Drew Fenton*

2. *Promissory Estoppel – Klaus Wagener*

The court finds that defendant Alan Heilpern solicited plaintiffs to become partners in an enterprise to solicit and obtain contracts to run emergency rooms. The solicitation was an offer to begin negotiations to see if the parties could agree on the terms of the partnership. Eventually they could not. The original solicitation/offer was no more than an offer to agree in the future. Defendant did not promise to agree to any specific terms; to the extent the defendant did promise plaintiffs' partnership shares, the promise was not enforceable. Even assuming an enforceable promise, there was no credible evidence that defendant did not intend to perform that promise when made. Each side hired an attorney and there ensued six months of negotiations; each side incurred attorney fees with respect to these negotiations. The only inference of a promise without intent to perform is the failure to agree on the partnership details. This is insufficient evidence to sustain plaintiffs' burden of proof.

4. *Breach of Fiduciary Duty* – Plaintiffs allege that in mid-1992, defendant created a new way of compensating the emergency room doctors, plaintiffs included. Plaintiffs allege that participating doctors agreed to accept a lower hourly wage in return for defendant's promise to create a new compensation pool consisting of all monies received by him and generated by participating doctors. Defendant contends that the new pool was not all the money generated by the doctors' efforts, but rather a pool consisting of the money produced by reducing the doctors' previous hourly wages. These monies were to be re-

allocated according to the amounts each generated – thus increasing the total compensation to those working harder. Plaintiffs contend that distribution of the new pool as they saw it created a fiduciary duty by defendant toward them.

The court finds that defendant did not intend to nor did he create a pool of money consisting of all monies generated by the plaintiffs. Defendant properly distributed the money due defendants. No fiduciary duty was created; even if it could be argued that one was created, defendant properly disbursed the monies due plaintiffs.

3. *Accounting* – The court finds judgment for defendant inasmuch as the money was properly distributed.

The sixth cause of action for sexual discrimination and sexual harassment remains set for jury trial. Upon conclusion of the jury trial, defendant shall submit a judgment to this count which conforms with this statement of decision and the eventual jury trial.

Dated: JUN - 4 1996

RICHARD KALUSTIAN
RICHARD P. KALUSTIAN
Judge of the Superior Court

MOTION FILED
JUL 2 2 1999

No. 98-2052

IN THE
# Supreme Court of the United States

DREW FENTON and KLAUS WAGENER,
*Petitioners,*

v.

UNIHEALTH AMERICA, INC., *et al.*,
*Respondents.*

**On Petition for Writ of Certiorari to the California Supreme Court**

## MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE* AND BRIEF *AMICI CURIAE* OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE, THE AMERICAN ACADEMY OF EMERGENCY MEDICINE, CALIFORNIA STATE CHAPTER AND THE AMERICAN COLLEGE OF LEGAL MEDICINE IN SUPPORT OF PETITIONERS

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IN THE

# Supreme Court of the United States

No. 98-2052

DREW FENTON and KLAUS WAGENER,
*Petitioners,*

v.

UNIHEALTH AMERICA, INC., *et al.*,
*Respondents.*

**On Petition for Writ of Certiorari to the California Supreme Court**

## MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE*

The American Academy of Emergency Medicine represents the interests of more than 2500 medical doctors who practice the specialty of emergency medicine. The AAEM was established in 1993 to promote fair and equitable practice environments necessary to allow emergency physicians to deliver the highest quality of patient care. There are, in turn, state chapters of the national organization.

The American Academy of Emergency Medicine, California State Chapter, is an advocate for its physician members concerning emergency medical practice issues in the State of California, the situs of the issue in this petition.

Founded in 1960, The American College of Legal Medicine ("ACLM") is an organization of professionals concerned with issues arising at the convergence of law

and medicine. ACLM's membership consists of approximately 1300 professionals, including physicians and scientists in most specialties, management and employees in various healthcare fields, and plaintiff, defense, corporate and public interest attorneys. ACLM is officially recognized by the American Medical Association as the society that represents legal and medical specialists.

The petition in this case presents an issue of vital interest to these *amici* at the national level and at the state level relating to the scope of medical payment reassignments. The California Supreme Court decision in this case undermines the federal law, regulations and policies that Congress intended to create for the payment or reassignment of federal, Medicare benefits.

Therefore, *amici* request this Court to accept the attached brief in support of the petition for certiorari in this case. Petitioners have consented to the filing of this brief, respondents have not consented.

Respectfully submitted,

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## QUESTION PRESENTED

Under 42 U.S.C. section 1395u, which limits the assignment of Federal funds earned by physicians who treat Medicare patients, can those physicians assign the public funds due them to a corporation which engages them to work as independent contractors to staff a hospital emergency department?

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IN THE

# Supreme Court of the United States

No. 98-2052

DREW FENTON and KLAUS WAGENER,
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v.

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**On Petition for Writ of Certiorari to the California Supreme Court**

## BRIEF *AMICI CURIAE* OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE, THE AMERICAN ACADEMY OF EMERGENCY MEDICINE, CALIFORNIA STATE CHAPTER AND THE AMERICAN COLLEGE OF LEGAL MEDICINE IN SUPPORT OF PETITIONERS

## INTEREST OF THE *AMICI CURIAE* [1]

The American Academy of Emergency Medicine ("AAEM") is the specialty society of Emergency Medicine. AAEM is a democratic organization of over 2,500 specialists who have achieved certification by either the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine.

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1 Petitioners have consented to the filing of this brief, respondents have not consented. This brief was not authored in whole or in part by counsel for a party, and no person or entity, other than the *amici curiae* made a monetary contribution to the preparation and submission of this brief.

AAEM, California Chapter, is the local, directly affected state chapter.

The American College of Legal Medicine ("ACLM") is an organization of professionals concerned with issues arising at the convergence of law and medicine. ACLM's membership consists of physicians, scientists, management and employees in various healthcare fields, and plaintiff, defense, corporate and public interest attorneys.

The issue at stake in this case is of direct concern to *amici* and their members. *Amici are* deeply committed to fair and equitable practice environments necessary to allow physicians to deliver the highest quality of patient care. *Amici* believes that billing and payment improprieties, in the system of Medicare medical services administered under federal law by the Health Care Financing Administration (HCFA), impede physicians' abilities to provide quality patient care. Therefore, amici's member phsyicians—intended recipients of Medicare benefits payments from HCFA for medical services they provide to patients—have a vital stake in ensuring that the medical reimbursement provisions of the Social Security Act and HCFA's regulations and policies to implement it, are accurately applied and followed, as intended by Congress.

The decision by the California Court of Appeal for the Second Appellate District—that 42 U.S.C. Section 1395u (b)(6) of the federal Social Security Act ("Act") was not violated by *Respondents'* receipt of federal funds due *Petitioners* (review of which was denied by the California Supreme Court)—is an erroneous interpretation of the Act and HCFA's implementing regulations and policies. Left unchanged, the California court decision is an impermissible state interpretation of 42 U.S.C. Section 1395u (b)(6), in violation of Congress' intent.

## STATEMENT

Respondent California Medical Center (CMC) is an inner-city hospital primarily serving indigents located in downtown Los Angeles. Pet. App. 2a. Respondent Unihealth is the parent company of CMC. Pet. App. 5a.

The operation of the emergency room at CMC was contracted out to California Emergency Medicine Services (CEMS) a business entity which, in turn, was owned and managed by Respondent Neil Heilpern, M.D. (Heilpern). Pet. App. 2a. Petitioners Drew Fenton, M.D. (Fenton) and Klaus Wagener, M.D. (Wagener) both worked for CEMS in the emergency room of CMC.

Petitioner Wagener had no written contract with CEMS. He was informed by Respondent Heilpern, orally, that he would work in the emergency department at an hourly rate as an independent contractor. The written contract presented by CEMS and signed by Petitioner Fenton, provided that emergency physicians would work at CMC at a stipulated hourly rate as independent contractors. The contracts also provided that all of their billings would be owned by CEMS. Pet. App. 5a.

The federal Medicare statute provisions of the Social Security Act provide in relevant part: "No payment under this part for a service provided to any individual shall . . . be made to anyone other than such individual or . . . other person who provided the service, except that payment may be made to the employer or such physician or other person . . . or (where the service was provided in a hospital, critical access hospital, clinic, or other facility) to the facility in which service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service . . ." 42 U.S.C. Section 1395u (b)(6)(A)(ii); 42 C.F.R. 424.80(b)(2). Pet. App. 25a.

On appeal, Petitioners contended that the assignment of Medicare funds due them—but required by CEMS to be made to Respondent Heilpern and/or CEMS—was invalid. Petitioners asserted that, by law, the involved Medicare funds can only be paid to them, the doctors who performed the medical services. Thus, the statutory exceptions to the prohibition against fund reassignments to others did not apply ". . . because (a) Fenton was not an employee (therefore the "employer" exception to the prohibition on assignment does not apply), and (b) the funds can only be paid to a professional corporation contracting to provide emergency room services when the services are provided by employee physicians." Pet. App. 24a.

The California Court of Appeal found that Respondent CEMS lawfully received the Medicare reimbursement payments due Petitioners under the Act's exception for "facilities." Pet. App. 25a. Petitioners' Petition for Rehearing and Petitioners' Petition for Review were, respectively, denied by The Supreme Court of California. Pet. App. 2b and Pet. App. 1c.

## INTRODUCTION AND SUMMARY OF ARGUMENT

The decision of the California Court of Appeal for the Second Appellate District, as affirmed by The Supreme Court of California ("the California Courts"), erroneously interprets and misapplies the federal Social Security Act's ("Act") stated criteria for the reassignment of Medicare payments.

The "facility" exception—to the Act's prohibition against reassignment of Medicare payments—permits reassignment of Medicare payments to hospitals or other facilities ". . . in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service."

By finding that CEMS may legally receive Medicare payments due Petitioners under the "facilities" exception, the California Courts ignored the fact that CEMS is not a "facility" in which Petitioners' services were provided, as required. Further, the California Courts ignored the fact there were no contractual arrangements between the Petitioner physicians and the hospital (CMC) facility under which CMC, in turn, submitted bills for Petitioners' services, as required.

In addition, the California Court decisions squarely conflict not only with the plain language of the Medicare statute but also with its legislative history, the statute's implementing regulations, applicable provisions of HCFA's Medicare Carriers Manual and subsequent policy statements also promulgated by HCFA—the federal organization which administers the Medicare program and payments.

This Court should restore the scope of the Congressionally-intended exceptions—to the prohibition against reassignment of Medicare payments—as stated in the Act's Medicare statute. Further, this Court should make clear that additional exceptions to the Medicare statute's reassignment prohibition, if any, are the province of the U.S. Congress and HCFA which is charged with the responsibility of implementing the Congress' Medicare directives.

## ARGUMENT

### I. THE CALIFORNIA COURTS HOLDING CONFLICTS WITH THE SOCIAL SECURITY ACT'S REQUIRED CRITERIA FOR A "FACILITY" TO RECEIVE REASSIGNMENT OF MEDICARE BENEFITS AND MADE NO INQUIRY INTO RECIPIENT CEMS' ELIGIBILITY UNDER THE ACT TO RECEIVE THE MEDICARE BENEFITS DUE PETITIONERS

The "facility" exception to the Social Security Act's prohibition against reassignment of Medicare payments specifically provides that:

> "(6) No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that (A) payment may be made (I) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer; or (ii) (where the service was provided in a *hospital*, critical access hospital, clinic, *or other facility*) to the facility *in which the service was provided* if there is a *contractual arrangement between such physician or other person and such facility* under which *such facility submits the bill for such service. . .*" (emphasis added) (42 U.S.C. Section 1395u(b)(6)(A)(ii).

The plain language of the statute clearly indicates there are three criteria for the facility exception to the prohibition against Medicare payment reassignment: (1) the service must be provided in the hospital or other facility, (2) there must be a contractual arrangement between the physician or other person and the hospital or other facility, and (3) the hospital or other facility must sub-

mit the bill for payment of the service. As stated, the Act's three criteria are interrelated; they work in concert; they do not stand separate and alone.

However, the California Court of Appeal apparently concluded that because Fenton's and Wagener's physician services were indeed provided in a hospital (CMC), the statutory requirements for the "facility" exception to the act's prohibition against Medicare payment reassignments were met. In making this apparent determination, the California Court of Appeal (while disregarding Fenton's and Wagener's request for that court to take judicial notice of applicable interpretive provisions in the Manual of HCFA Division of Benefits Services) declared ". . . we do not see why an agency administering the Medicare funds would adopt a view that is contrary to the plain language of the federal statutes providing such funds may be paid to a care facility." Pet. App. 25a. Yet, the California Courts' conclusion includes no analysis or determination that the Act's criteria for a "facility" exception were actually met by CMC, by CEMS or by Respondent Heilpern.

Amici submits to this Court that HCFA, the agency administering the Medicare funds, has not adopted a view that is contrary to the plain language of the applicable federal statutes. To the contrary, the plain language of the Social Security Act and its Medicare payment provisions are clear. The Act requires a "facility" payment reassignee to meet three interrelated criteria. Yet, the California Court erroneously based its decision only on one of the Act's three interrelated criteria—that the involved physician services were performed in a hospital facility.

The California Court's holding, that meeting one of the Act's criteria for this payment reassignment exception—

performance of the medical services in a hospital facility—satisfies all three required criteria should be rejected for a simple reason: the Act means what it says. In any case of statutory construction, the inquiry begins with the "language of the statute." *Bailey v. United States,* 516 U.S. 137, 144 (1995). Where, as here, "the statutory language provides a clear answer, it ends there as well." *Hughes Aircraft Co. v. Jacobson,* No. 97-1287, slip op. At 5 (U.S. Jan. 25, 1999).

## II. THE CALIFORNIA COURTS' HOLDING SQUARELY CONFLICTS NOT ONLY WITH THE PLAIN LANGUAGE OF THE ACT'S MEDICARE STATUTE BUT ALSO WITH THE STATUTES' LEGISLATIVE HISTORY, HCFA'S IMPLEMENTING REGULATIONS AND SUBSEQUENT AND CURRENT HCFA POLICY STATEMENTS AND INTERPRETATIONS

### A. The California Courts' Decision Conflicts With the Act's Legislative History

Although the Court's interpretive process need go no further, because the statutory language is straightforward and unambiguous, the legislative history of the Act's Medicare statute supports an ordinary and clear understanding of the need for and Congressional limitations placed on exceptions to the prohibition against the reassignment of Medicare benefits.

Section 1842(b) of the Social Security Act ("Act"), 42 U.S.C. Section 1395u(b)(6), establishes the general principle that Medicare program payments should be made to the beneficiary or, under an assignment, to the physician who provides the physician service. This principle was developed to ensure accountability and to prevent "factoring" (a practice of selling accounts receivable to a third party) that Congress specifically found to be abusive in the payment of Medicare benefits. (See HCFA

Ruling No. 98-1 Date: December 11, 1998, Reassignment of Medicare Benefits, p. 3).

The Act's legislative history demonstrates quite clearly that, by preventing a third party from obtaining payment from the Medicare program, Congress hoped to destroy a third party's incentive to engage in abusive billing practices or to submit claims for services that were not rendered (see March 26, 1997 interpretive letter from HCFA Administrator Bruce Vladeck to Coastal Physician Services, Inc. attached). The HCFA interpretive letter further states that Congressional reports expressly conclude: "Such reassignments have been a source of incorrect and inflated claims for services and have created administrative problems with respect to determinations of reasonable charges and recovery of overpayments. . ." H. Rep. No. 92-131, at 104 (1971). *Id.* at 2.

### B. The California Court Decision Conflicts With HCFA's Regulations Implementing the Act

HCFA, the federal organization charged with crafting and implementing the regulations to carry out the Medicare payment provisions of the Social Security Act, has correctly concluded that "in light of these (Congressional) findings (to eliminate a third party's incentive to engage in abusive billing practices), our policies have been designed to limit the extent to which Medicare pays individuals or entities that do not directly provide medical case." *Id.* at 2.

Accordingly, HCFA's implementing regulations clearly limit the extent to which Medicare pays individuals or entities that do not directly provide medical care. The HCFA regulations at 42 CFR Section 424.73 entitled "Prohibition of assignment of claims by providers," restates the basic prohibition against reassignments and spe-

cifically lists the agency's exceptions to that prohibition as follows:

"(a) Prohibition. Except as specified in paragraph (b) of this section, Medicare does not pay amounts that are due a provider to any other person under assignment, or power of attorney, or any other direct payments arrangement.

(b) Exceptions to the prohibition—(1) Payment to a government agency or entity. . . . (2) Payment under assignment established by court order. . . . (3) Payment to an agent. Medicare may pay an agent who furinshes billing and collection services to the provider if the following conditions are met: (1) The agent receives the payment under an agency agreement with the provider; (ii) The agent's compensation is not related in any way to the dollar amounts billed or collected; (iii) The agents compensation is not dependent upon the actual collection of payment; (iv) The agent acts under payment disposition instructions that the provider may modify or revoke at any time; and (v) The agent, in receiving the payment, acts only on behalf of the provider. Payment to an agent will always be made in the name of the provider."

Yet, the California Court in rendering its decision, cites the HCFA implementing regulations but once and, erroneously, does not discuss or analyze the applicability of the HCFA regulations to the issues and parties at all. Instead, the California Court of Appeal characterizes Petitioner Fenton's and Petition Wagener's argument against Medicare payment assignment to Respondent CEMS/Heilpern as a mere attempt ". . . to escape this assignment of funds. . ." Pet. App. 24a.

If the California Court had seriously reviewed and considered the specific requirements for exceptions to prohibition against Medicare payment reassignments stated in

HSFA's implementing regulations, it would have ruled in Petitioner Fenton's and Petitioner Wagener's favor.

### C. The California Court Decision Conflicts With HCFA's Interpretive Medicare Program Manual

The HCFA was established in 1972 to administer the federal Medicare program, among others. In the twenty six years since its establishment, HCFA has promulgated a countless number of Medicare interpretive regulations and policy statements. Perhaps none of HCFA's voluminous interpretive statements is more important to the proper determination of the issue posed here than its Medicare Program Manuals, in particular, HCFA's Medicare Carriers Manual Part 3, Chapter III—Claims, Filing, Jurisdiction and Development Procedures ("the Manual").

Section 3060 of the Manual is the daily, practical guide developed and used by HCFA officials to review the propriety of asserted Medicare payment reassignments. In the California Court holding, that court gave scant mention to HCFA's interpretive manuals and only in its subsequent Order Denying Petition for Rehearing and Modifying Opinion, did that court even grant Petitioners' request to take judicial notice of the HCFA Manual cited. Pet. App. 2b.

A momentary review of Section 3060 by the California Court would have led that court to conclude Respondent CEMS/Heilpern does not qualify under HCFA's Manual as a "facility" exception entitled to a reassignment of Petitioners' Medicare benefits payments. Specifically, Section 3060.2—Payment to Facility in Which Services Are Performed—is controlling for this Court's proper review of the issue presented and why this Court should grant Petitioners' Writ of Certiorari.

The Manual's Section 3060.2B—Scope of the Term "Facility"—states: ". . . the term 'facility' is limited for purposes of this rule to institutions which make provision for furinshing services to individuals as inpatients, i.e., hospitals, university medical centers that own and operate hospitals, skilled nursing facilities, nursing homes, the skilled nursing facility or nursing home units of retirement homes, and other institutions of a similar nature. . ." Clearly, this enumeration of included "facilities" does not include a corporation such as CEMS which was owned and operated by Respondent Heilpern for the purpose of providing independent contractor physicians to staff the emergency room at Respondent CMC. Pet. App. 2a.

Further, the Manual's Section 3060.2D—Indirect Contractual Arrangement—provides, in part, that "a contractual arrangement between a physician and a facility in which the phsyician performs services may exist indirectly by reason of a contractual arrangement between the physician and some other entity and a contractual arrangement between that entity and the facility."

Assuming arguendo that the California Court determined (but did not articulate) Petitioners had an "indirect contract" with Respondent facility CMC, its reasoning still remains flawed and would not lead to a judicial conclusion that permits CEMS to receive an assignment of Medicare benefits due Petitioners—the balance of Section 3060.2D still requires the facility (Respondent CMC) to have a direct contractual arrangement with the physician, and the facility ". . . must certify that it will bill and receive payment for the physician's services only so long as it has this direct arrangement." The California Court decision does not mention nor did it inquire about any contractual relationship between Petitioners and Respondent CMC, as required.

The California Court's open disregard if not outright dismissal of HCFA's interpretive Medicare Manuals is no more clear than its failure to review and apply EXAMPLE 2 of Section 3060.2D of the Manual. EXAMPLE 2 provides:

> a professional corporation enters into a contractual arrangement with a hospital to provide physician emergency room services for the hospital and ". . . subcontracts the responsibility for providing the emergency room services to physicians who are independent contractors. *Even though the corporation may not itself bill and receive the payments for the physician services*, the hospital may do so if it enters into direct contractual arrangements with the physicians for this purpose" (emphasis added).

Here, Respondent Heilpern/CEMS subcontracted the responsibility for providing the emergency room services to Petitioners Fenton and Wagener who, under Heilpern/CEMS' contract, are independent contractor physicians, as in EXAMPLE 2. Yet, the California Court decision makes no mention or review of the applicability of the Manual, the Manual's EXAMPLE 2 or the required contractual relationship between Petitioners and Respondent CMC.

Again, the California Court merely concludes that because Petitioners' physician services were performed in a facility hospital (CMC), ". . . we do not see why an agency administering the Medicare funds would adopt a view that is contrary to the plain language of the federal statutes providing such funds may be paid to a care facility." Pet. App. 25a.

### D. The California Court Decision Conflicts With Current HCFA Policy Statements

Although the Act's provisions and HCFA's regulations and applicable manual to limit the reassignment of Medi-

care benefits are clear. HCFA continues to restate and reaffirm the Act's limits to reassignments because of the constant need to do so.

In a March 26, 1997 letter from then HCFA Administrator Bruce C. Vladeck to counsel for Coastal Physician Services, Inc., Mr. Vladeck specifically addressed the issue of reassignment of Medicare payments for physician services rendered in hospital emergency rooms.

According to the Administrator's letter, Coastal had a contractual relationship with the involved hospital and a contractual relationship with physicians. There, as here, the contract expressly claimed the physicians are independent contractors, not employees.

In its previous correspondence to HCFA, Coastal requested that HCFA ". . . postpone or modify its policies to enable Coastal to continue to receive Medicare payments for the services provided by contractual physicians within the emergency rooms of various hospitals." Consistent with the Act and HCFA's implementing regulations, Administrator Vladeck responded "we are not able to adopt your suggestion." There, as here, a corporation which staffed hospital emergency rooms sought to expand an exception to the reassignment prohibition.

In Coastal, Administrator Vladeck acknowledged that the Act does contain express exceptions. However, Administrator Vladeck correctly asserted that "exceptions to a statutory prohibition are generally construed narrowly, in order to preserve the intent of the general rule."

As stated in footnoe three of Administrator Vladeck's interpretive policy letter and equally applicable to Petitioners' Writ of Certiorari,

> "this principle is particularly applicable here because the statute specifically restricts the agency's ability

> to make payment. Payments of money from the Federal Treasury are limited to those authorized by statute. *Office of Personnel Management v. Richmond*, 496 U.S. 414, 416 (1990). Indeed, the Court has recognized that the fundamental purpose of the Appropriations Clause of the Constitution "[i]s to assure that public funds will be spent according to the letter of the difficult judgments reached by Congress as to the common good, and not according to the favor of Government agents or the individual pleas of litigants." *Richmond*, 496 U.S. at 428. See also, *United States v. MacCollum*, 426 U.S. 317, 321 (1976) ("The established rule is that expenditures of public funds is proper only when authorized by Congress, not that public funds may be expended unless prohibited by Congress").

In addition, HCFA has developed for its and interested parties' use, a written series of "questions and answers" concerning hospital emergency rooms and corporations which attempt to staff hospital emergency rooms with independent contractor physicians.

Apparently unknown to the California Court, the HCFA document is entitled "Question and Answer (Q and A) Document on the Compliance Scenarios Prepared by the Emergency Department Medical Group Industry" ("the document").

Several of the questions posed in the document, and the issue raised by Petitioners' Writ of Certiorari, need to be answered definitively by this Court because the Act, HCFA's implementing regulations and HCFA's interpretive Medicare Manuals are, in many instances, not being followed.

Petitioners' issue is, in part, ". . . can those physicians assign the public funds due them to a corporation which engages them to work as independent contractors to staff a hospital emergency department?"

The twelfth (12) question in the HCFA document, perhaps asks the ultimate question and, in part, answers Petitioners issue as follows:

> "Q. What type of payments and/or billing arrangements are acceptable?
>
> A. In order for HCFA to make payment to an agent, the payment to agent conditions specified in 424.73(b)(3) of the Medicare regulations and in section 3060.10 of the Medicare Carriers Manual (MCM) must be met. For electronic funds transfers, payment must go directly into the physician's bank account. See section 3060.11 of the MCM.
>
> In order for the billing agreement to be acceptable to Medicare, the agreement must ensure that the physician billing records will be available and accessible to the physician on a timely basis. In addition, the billing agent must be paid only by the physician, and can not be compensated by any other third party. HCFA must be assured that the billing agent's sole responsibility is to act on behalf of the physician."

The HCFA focus, unlike the California Court, is on the patient, the payment of public funds for the patient and the payment of public funds to the physician who performs the medical service because the Act requires it to do so. The California Court decision is not based on an all-inclusive understanding of the Act, its requirements and HCFA's regulations and policies which implement the Congressional directives stated in the Act.

*Amici* urges this Court to grant Petitioners' Petition for Writ of Certiorari in order to decide the issue posed and to make clear that Congress' prohibitions against the assignment of Medicare payments are followed; that the Act's exceptions to these prohibitions are adhered to and that expansion of these exceptions, if any, is the province

of Congress and HCFA, which is charged with the duty to implement Congress' legislative directives and to administer the federal Medicare program.

## CONCLUSION

For the reasons stated above, *Amici* requests that Petitioners writ be granted.

Respectfully submitted,

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In The

# Supreme Court of the United States

DREW FENTON and KLAUS WAGENER,

*Petitioners,*

v.

UNIHEALTH AMERICA, INC., et al.,

*Respondents.*

**On Petition For Writ Of Certiorari To The California Supreme Court**

## REPLY TO OPPOSITION TO PETITION FOR CERTIORARI

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## INTRODUCTION

The most striking thing about Respondents' Opposition to the Petition is what it does *not* say. Nowhere in the Opposition do Respondents argue that section 1395u allows carriers to pay Medicare fees due to physicians to corporations which engage them to work in hospitals as independent contractors. Instead of meeting Petitioners' legal contentions head on, Respondents attempt to avoid the force of those arguments by using a variety of evasive strategies.

As shown below, none of those strategies is successful. Petitioners have shown that the California Court of Appeal was flatly wrong in its decision of a question of Federal law which is profoundly important to physicians and patients throughout the country. This Court should grant the writ in order to establish definitively and unmistakably that arrangements such as that CEMS entered into with the physicians it engaged are unlawful, and must be discontinued.

## I. THE FEDERAL ISSUE WAS PROPERLY RAISED AND CONSIDERED ON APPEAL.

Respondents assert that the Federal issue Petitioners have presented to this Court was not properly raised in the California courts (Opposition, pp. 1-2, 7-10). That is not the case.

Respondents accurately point out that Petitioners did not raise the issue in the trial court (Opposition, pp. 1-2), but erroneously assert that Petitioners failed to comply

with the provision of Rule 14(1)(g)(i) which requires disclosure of the stages at which the Federal issue was raised (Opposition, pp. 1-2), and that Petitioners misrepresented the facts in that regard (Opposition, pp. 6-7). In fact, Petitioners fully and accurately disclosed in the Petition (at pp. 4-5) that the issue was first raised in the Court of Appeal, was decided on the merits by the Court of Appeal, and was again raised in Petitioners' petition to the California Supreme Court.

Crucially, Respondents are wrong in asserting that Petitioners failed to raise the issue in accordance with California procedure. While the *general* rule is that California appellate courts will not consider issues not previously raised in the trial courts, there is an exception for issues of pure law to be decided on undisputed facts. Such issues may be raised, and the appellate courts have discretion to consider them. *Ward v. Taggart*, 51 Cal.2d 736 (1959).

The issue under 42 U.S.C. section 1395u Petitioners raised here was a pure question of law on the basis of undisputed facts, and the Court of Appeal *did* exercise its discretion to decide it on the merits. It is therefore properly before this Court.

Despite Respondents' claim that the section 1395u is "factually intensive (Opposition, p. 7)," it is in reality a pure question of law on the undisputed facts:

(1) Section 1395u(b)(6)(A) prohibits physicians from assigning their Medicare earnings to a corporation which engages them to work in a hospital department under a contract with the hospital to staff that department *unless* the physicians are *employees* of the corporation.

(2) It is undisputed that Respondent CEMS had an exclusive contract to staff the Emergency Department at CMC, and that it engaged Petitioners to work in that department. At trial, Petitioners contended they were employees, while *Respondent's* asserted they were independent contractors. Crucially, the *jury* decided that Petitioners were independent contractors, and Petitioners conceded the issue on appeal (see Appendix A to Petition, pp. 16-17). Thus, it was established indisputably on appeal that Petitioners were independent contractors. The fact that Petitioners took a contrary view at trial is irrelevant. It is also undisputed that Petitioners assigned all of the fees due them for their services, including Medicare fees, to Respondent CEMS in exchange for an hourly salary.

Those undisputed facts raise the legal issue Petitioners have put before this Court. No other factual findings are necessary to establish Appellants' legal right to an accounting for funds unlawfully assigned under section 1395u.

Thus, Petitioners have met this Court's requirements for jurisdiction of an issue on certiorari, and have established that the record in this case presents an important issue of Federal law in a form appropriate for this Court's review.

## II. THERE ARE NO INDEPENDENT STATE GROUNDS WHICH SUPPORT THE COURT OF APPEAL DECISION ON THE ILLEGALITY OF THE ASSIGNMENT UNDER 42 U.S.C. 1395U.

Respondents assert that the Court of Appeal had an adequate and independent state ground for it not to grant Petitioners an accounting, because that court found there was substantial evidence to support the existence of the contract under which Petitioners assigned the fees due them in exchange for an hourly salary (Opposition, pp. 12-13).

The contention is baseless. Petitioners do not contest the existence of the contract as described by the Court of Appeal and by Respondents. However, no amount of evidence as to that agreement and its terms can resolve the question presented here: the question of the *illegality* of that contract under section 1395u. The "substantial evidence" to which Respondents refer do *not* and cannot serve as an "adequate and independent nonfederal ground" for the Court of Appeal decision on the issue of the contracts' illegality under Federal law.

Respondent also contends that Petitioners should be barred from raising the question of the contract's illegality because Petitioners never *rescinded* the contract (Opposition, p.14). The argument is obviously specious. California law agrees with general Common Law in holding that an illegal contract is *void*, and that there is no need for rescission. *Estrada v. Alvarez*, 38 Cal.2d 386, 388 (1952); Witkin, Summary of California Law, Contracts, section 879 (9th ed. 1987).

## III. THIS CASE MEETS THE STANDARD OF RULE 10 BECAUSE THE COURT OF APPEAL DECISION WRONGLY DECIDES AN IMPORTANT QUESTION OF FEDERAL LAW THAT HAS NOT BEEN SETTLED BY THIS COURT.

Respondents assert that the standards for grant of certiorari under Rule 10 have not been met because the Court of Appeal did not "decide with any precision" the question raised here (Opposition, p. 15)."

Rule 10(c) provides for review by this Court where a state court has decided "an important question of federal law that has not been, but should be, settled by this Court . . . " That standard is met here.

Respondents do not, and could not reasonably, deny that the issue Petitioners raise here is an important issue of law which this Court has not, but should, settle. The amicus brief filed in this Court by the American Academy of Emergency Medicine, its California State Chapter, and the American College of Legal Medicine demonstrate that importance. Respondents contend, however, that the Court of Appeal did not decide that important issue "with any precision" because the discussion in the Court of Appeal opinion is "very brief" (Opposition, p. 15).

In fact, though brief, the decision of the Court of Appeal on the issue is eminently precise: it states clearly and directly that Petitioners assignment of funds was lawful under section 1395u(b)(6)(A)(ii)'s provision allowing payment "to a care facility." The problem with that statement is not that it is unclear, but that it is clearly *wrong*. Strikingly, Respondents do *not* even attempt to

argue that the statement was *correct* as a matter of Federal law.

## IV. RESPONDENTS' ARGUMENT THAT SECTION 1395U IS NOT APPLICABLE TO THEM BECAUSE IT GOVERNS MEDICARE "CARRIERS" IS WHOLLY SPECIOUS.

Respondents also seek to avoid the force of section 1395u by pointing out that it applies to Medicare "carriers (Opposition, p. 15-16)." The point is utterly devoid of merit. Section 1395u prohibits "carriers" from *paying* the public funds due to physicians under the Medicare program to entities like CEMS. It follows *logically* that a statute which prohibits the carrier from *paying* such funds to entities like CEMS also makes *illegal* for such entities to *receive* those funds. It is simply the other side of the coin.

If, as Respondents suggest, physicians cannot sue those whom they illegally assigned their Medicare fees for accounting, the intent of Congress in passing section 1395u will be defeated. Section 1395u *does* prohibit Petitioners from assigning Medicare fees to CEMS, it *does* prohibit the carrier from paying them to CEMS, and it *does* prohibit CEMS from receiving them. This Court should grant review in order to settle those points firmly in law for the benefit of physicians and patients throughout the country.

## CONCLUSION

For the reasons stated above and in the Petition, Petitioners respectfully request that the writ be granted.

Dated: August 6, 1999

Respectfully submitted,

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